DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 9, 2022

Administrator
Woodstone Senior Living
2020 Meyer Drive
New Ulm, MN 56073

RE: Project Number(s) SL29913015

Dear Administrator:

On August 8, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 19, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

June 16, 2022

Administrator
Woodstone Senior Living
2020 Meyer Drive
New Ulm, MN 56073

RE: Project Number(s) SL29913015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 19, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29913015-0 On May 16, 2022, through May 19, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 29 residents, all of whom received services under the provider's Assisted Living/with Dementia Care license. An immediate correction order was identified on May 18, 2022, issued for SL29913015-0, tag identification 2310. On May 18, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level 3, widespread.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 17, 2022, for the specific Minnesota	0 480		

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0 480	Continued From page 2 Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of two employees (unlicensed personnel (ULP)-C) observed to provide personal cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 510		

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0 510	Continued From page 3 situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 18, 2022, at approximately 8:18 a.m., the surveyor observed ULP-C providing personal cares for R8 while R8 was seated on the toilet. ULP-C donned gloves and handed a wet washcloth to R8 to wash her face and then provided a towel to dry. ULP-C washed R8's upper body including back, under arms, and under breasts, towel dried R8's upper body and then removed her gloves. Without performing hand hygiene, ULP-C donned new gloves, washed R8's legs and feet and towel dried the areas. ULP-C removed her gloves and without performing hand hygiene, donned new gloves. ULP-C assisted R8 to stand, washed her buttocks and towel dried the area. ULP-C handed another wet washcloth to R8 and asked her to wash between her legs and then assisted to towel dry the area. ULP-C removed her gloves, and without performing hand hygiene, donned new gloves. ULP-C applied lotion to R8's legs and removed her gloves. Without performing hand hygiene, ULP-C donned new gloves and assisted R8 to put on her shirt, incontinence brief, stockings, pants and shoes. ULP-C handed eyeglasses to R8 and combed her hair. ULP-C removed her gloves, and without performing hand hygiene, donned new gloves. ULP-C used toilet tissue to wipe R8's perineal (private) area, assisted her to stand and pulled up her brief and pants. ULP-C removed her gloves and without performing hand hygiene, donned new gloves. ULP-C applied a gait belt around R8's waist and, using the walker, positioned R8 in front of the sink to brush her teeth. When finished, ULP-C assisted R8 to her chair in her room. ULP-C	0 510		

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0 510	Continued From page 4 removed the gait belt, removed her gloves, and washed her hands in R8's bathroom sink. On May 18, 2022, at approximately 8:40 a.m., ULP-C indicated she should have performed hand hygiene after removing gloves and prior to donning new gloves. On May 18, 2022, at approximately 8:45 a.m., registered nurse (RN)-B stated gloves should be changed frequently when providing cares, especially when moving from one body part to another. RN-B stated expectations were high with hand hygiene and stated hand hygiene should be performed when removing gloves. The licensee's Handwashing policy, undated, directed hands should be washed after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to	0 680		

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0 680	Continued From page 5 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all of the required content. This had the potential to affect all 29 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Upon entrance to the facility on May 16, 2022, at approximately 1:00 p.m., the surveyor observed an Emergency Planning binder on a shelf in the common area, to the left of the entrance door.	0 680		

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0 680	Continued From page 6 The licensee's plan lacked the following required content: - development of policies/procedures to address: - evacuation plan; - use of volunteers; - arrangement with other facilities; and - EP training program for staff (including documentation of training provided). On May 19, 2022, at approximately 12:00 p.m., licensed assisted living director (LALD)-A, corporate director of nursing (CDON)-G, and lead care manager (LCM)-F verified the above. CDON-G stated staff were provided emergency preparedness training upon hire and annually using Educare training modules; however, not specifically on the licensee's emergency plan. The licensee's Emergency Preparedness Manual policy, undated, indicated the emergency preparedness manual would be available to staff at all times and would contain a plan for evacuation, elements of sheltering in place, temporary relocations sites, and details of staff assignments in the event of a disaster or an emergency. Also included, training and orientation for staff and residents regarding the emergency and disaster plan would occur twice per year (and at time of move in). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 7 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to	0 810		

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0 810	Continued From page 8 conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 19, 2022, at approximately 1:40 p.m. with Lead Care Manager (LCM)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LCM-F indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. During interview, LCM-F indicated that the fire safety and evacuation plan for the facility lacked these provisions.	0 810		

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0 810	Continued From page 9 Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, LCM-F stated that employees are provided training on fire safety and evacuation at orientation only. A policy was requested but one was not able to be provided. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. During interview, LCM-F provided documentation and stated that licensee had conducted evacuation drills for the employees on March 19, 2022, and on May 5, 2022, but did not have any documented drills prior to that. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 910 SS=C	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by:	0 910		

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0 910	Continued From page 10 Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a written contract with the following required content: - license number. R1's Woodstone Senior Living Resident Agreement, dated August 1, 2022, indicated the licensee held an Assisted Living with Dementia Care license and included the license number as "29913," which was the Health Facility ID Number (HFID) (unique number issued by the Minnesota Department of Health to identify the facility), not the license number. R2's Woodstone Senior Living Resident Agreement, dated January 11, 2022, indicated the licensee held an Assisted Living with Dementia Care license and incorrectly included the license number as "29913," which was the HFID, not the license number. R3's Woodstone Senior Living Resident Agreement, dated May 3, 2022, indicated the licensee held an Assisted Living with Dementia Care license and incorrectly included the license	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 910	Continued From page 11 number as "29913," which was the HFID, not the license number. On May 17, 2022, at approximately 8:45 a.m., corporate director of nursing (CDON)-G verified the contract included the HFID number, instead of the license number. CDON-G verified the same contract was received by all residents living in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This	01440		

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01440	Continued From page 12 requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of unlicensed staff as required for one of three unlicensed personnel (ULP)-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E had a hire date of January 10, 2022. ULP-E's record included a Personnel Performance Review, dated January 10, 2022, (61 days after hire date), identifying the performance review period as "30 Day Review" however, lacked evidence an RN conducted direct supervision of ULP-E within 30 days of performing delegated tasks. On May 19, 2022, at 9:08 a.m., licensed assisted living director (LALD)-A verified ULP-E performed assisted living services and delegated nursing tasks and verified the RN did not supervise ULP-E performing a delegated nursing task within 30 days as required.	01440		

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01440	Continued From page 13 The licensee's Supervision of Licensed and Unlicensed Personnel policy, undated, included, "Direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and has been trained and determined competent to perform all the tasks assigned." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01610		

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01610	Continued From page 14 review, the licensee failed to ensure the registered nurse (RN) completed an initial, comprehensive nursing assessment prior to signing the assisted living contract/providing services for one of three residents (R2) as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted for services on January 26, 2022. R2's diagnoses included cerebral infarction (damage to tissues in the brain), major depressive disorder and chronic kidney disease. On May 17, 2022, at approximately 11:13 a.m., the surveyor observed R2 sitting in a chair in his room, watching television. R2's Service Plan (Private) - Addendum to Contract, dated February 11, 2022, indicated R2 received services including assistance with bathing, grooming, medication administration, blood glucose monitoring, housekeeping and vital signs monitoring. R2's Woodstone Senior Living Resident Agreement was signed January 11, 2022.	01610		

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	29913	A. BUILDING: _____ B. WING _____	05/19/2022

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01610	Continued From page 15 R2's record included an Assessment As Of Date intended as the initial assessment, which indicated the assessment was completed in person by the RN on January 28, 2022, not prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moved in, whichever was earlier, as required. On May 18, 2022, at approximately 11:48 a.m., RN-B confirmed R2's assessment date was two days after R2 moved into the facility. The licensee's Assessment Process policy, undated, indicated an assessment would be completed in person prior to executing a contract with the facility and an initial assessment would be completed by the RN. After the assessment, the RN would propose a temporary service plan before the resident signs a contract with the community or the date the resident moves in, whichever is earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 16 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 14 days after the initiation of services, for one of three residents (R2) as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted for services on January 26,	01620		

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01620	Continued From page 17 2022. R2's diagnoses included cerebral infarction (damage to tissues in the brain), major depressive disorder, and chronic kidney disease. On May 17, 2022, at approximately 11:13 a.m., the surveyor observed R2 sitting in a chair in his room, watching television. R2's Service Plan (Private) - Addendum to Contract, dated February 11, 2022, indicated R2 received services including assistance with bathing, grooming, medication administration, blood glucose monitoring, housekeeping and vital signs monitoring. R2's Woodstone Senior Living Resident Agreement was signed January 11, 2022. R2's record included a Master Care Plan - With Services, dated February 10, 2022, intended to be the 14-day assessment. The assessment indicated R2 required help with bathing, nurse follow-up on health issues, appointment and transportation scheduling, housekeeping, laundry, and reducing fall risk. The assessment was completed 15 calendar days after the initiation of services, instead of no more than 14 days after initiation of services, as required. On May 18, 2022, at approximately 11:48 a.m., RN-B confirmed R2's 14-day assessment date was late and was not completed within 14 days after the initiation of services. The licensee's Nursing Assessment policy, undated, indicated the RN would complete a resident reassessment no more than 14 calendar days after initiation of services and, if needed,	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 18 finalize the service agreement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a current written service plan was finalized no later than 14	01640		

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01640	Continued From page 19 calendar days after the date that services were first provided, for one of three residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted for services on January 26, 2022. R2's diagnoses included cerebral infarction (damage to tissues in the brain), major depressive disorder and chronic kidney disease. On May 17, 2022, at approximately 11:13 a.m., the surveyor observed R2 sitting in a chair in his room, watching television. R2's Woodstone Senior Living Resident Agreement was signed January 11, 2022. R2's Service Plan (Private) - Addendum to Contract, dated February 11, 2022, indicated R2 received services including assistance with bathing, grooming, medication administration, blood glucose monitoring, housekeeping, and vital signs monitoring. The service plan was signed by R2 and the registered nurse (RN) on February 11, 2022, 16 calendar days after the initiation of services, instead of no later than 14 calendar days, as required.	01640		

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	29913	A. BUILDING: _____ B. WING _____	05/19/2022

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01640	Continued From page 20 On May 18, 2022, at approximately 11:48 a.m., RN-B confirmed R2's service plan date was late and was not completed within 14 days after the initiation of services. The licensee's Development of the Service Plan policy, undated, indicated a finalized service plan would be completed no later than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including	01650		

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	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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01650	Continued From page 21 identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's service plan lacked the following: - the fees for services according to the resident's current assessment and resident preferences; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility;	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01650	Continued From page 22 - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On May 17, 2022, at approximately 11:35 a.m., the surveyor observed R1 sitting in a chair in the dining room with eyes closed. R1's Master Care Plan - With Services, dated November 12, 2021, indicated R1 received services which included assistance with personal cares, bathing, medication administration, eating and toileting. The service plan lacked the required content noted above. On May 17, 2022, at approximately 10:43 a.m., registered nurse (RN)-B confirmed the service plan for R1 lacked the required content noted above and stated the service plan was not printed in the correct format, therefore, the information above was not included. The licensee's Development of the Service Plan policy, undated, indicated the service plan would clearly identify the fees for services, the schedule and methods of monitoring assessment of the resident, the schedule and methods of monitoring staff providing services, and the plan for contingency action that included what actions would be taken if the scheduled services cannot be provided. Also, the policy indicated the service	01650		

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	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01650	Continued From page 23 plan would identify how the resident or the resident's responsible person could contact a representative of the licensee, the name and telephone number of the resident's contact person in case of an emergency including identification of and contact information for who has the authority to sign for the resident in an emergency, and the circumstances in which emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others	01700		

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	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01700	Continued From page 24 who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment with the required content for two of three residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on May 16, 2022, at approximately 1:45 p.m., licensed assisted living director (LALD)-A and RN-B stated the licensee provided medication management services to the licensee's residents. R1 R1's record lacked evidence the RN had conducted a medication assessment to include:	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01700	Continued From page 25 - identification and review of all medication. On May 17, 2022, at approximately 11:35 a.m., the surveyor observed R1 sitting in a chair in the dining room with eyes closed. R1 had a contract dated effective August 1, 2021, signed by R1's representative on August 2, 2021. R1's Master Care Plan - With Services, dated November 12, 2021, indicated R1 received services which included assistance with personal cares, bathing, medication administration, eating, and toileting. The included medication assessment and medication management plan lacked the above required content. R1's prescriber orders dated April 17, 2022, included one pain reliever, one antibiotic, two supplements, two eye drops, one sleep aide, one antianxiety, and one antidepressant. R2 R2's record lacked evidence the RN had conducted a medication assessment to include: - identification and review of all medications. On May 17, 2022, at approximately 11:13 a.m., R2 was observed sitting in a chair in his room, watching television. R2's Woodstone Senior Living Resident Agreement was signed January 11, 2022. R2's Service Plan (Private) - Addendum to Contract, dated February 11, 2022, indicated R2 received services including assistance with bathing, grooming, medication administration, blood glucose monitoring, housekeeping, and vital signs monitoring. The included medication	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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01700	Continued From page 26 assessment and medication management plan lacked the above required content. R2's current medication list printed May 18, 2022, included an insulin pen, two antidepressants, a medication to lower bad cholesterol, a supplement, one antihypertensive (lower blood pressure), one medication to prevent blood clots, and one dialysis medication. On May 19, 2022, at approximately 11:01 a.m., RN-B confirmed the assessments lacked the above required content. The licensee's Implementation of Medication Orders policy, undated, indicated the RN would complete a face-to-face assessment with the resident and would review all medications the resident was known to be taking. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 27 the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were transcribed as prescribed for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Master Care Plan - With Services, dated November 12, 2021, indicated R1 received services to include medication management with medication administration. On May 17, 2022, at approximately 11:35 a.m., the surveyor observed R1 sitting in a chair in the dining room with eyes closed. R1's Medications-Current, printed May 18, 2022, included Mapap (pain reliever same as Tylenol) ordered January 24, 2019, with directions to give 325 milligrams (mg) two tablets by mouth every four hours as needed, with strength incorrectly noted as "500 mg," instead of 650 mg. On May 19, 2022, at approximately 10:50 a.m.,	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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01760	Continued From page 28 registered nurse (RN)-B verified the strength was incorrectly transcribed and stated could be confusing to staff administering the medication. The licensee's The Medication System policy, undated, indicated the medication system contained checks and balances to decrease the potential for medication errors. The policy noted the RN transcribes the prescriber's orders and supervises the system to assure that medications are being administered and documented accurately. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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01820	Continued From page 29 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted January 22, 2019, and had diagnoses including dementia with behavioral disturbances, hallucinations, major depressive disorder and anxiety disorder. R1's Master Care Plan - With Services, dated November 12, 2021, indicated R1 received services to include medication management with medication administration. On May 17, 2022, at approximately 11:35 a.m., the surveyor observed R1 sitting in a chair in the dining room with eyes closed. R1's record included an encounter note from the nurse practitioner, dated March 29, 2022, with new order to "Trial scheduling Seroquel [used to treat mental/mood disorders] 12.5 mg [milligrams] po [by mouth] qd [every day] in afternoon x 2 weeks re: eval [evaluate] next rounds sooner if adverse S/E [side effects] noted." R1's record included a nurse practitioner visit note dated April 12, 2022, indicating the acute visit was for "Med [medication] change follow-up, and concerns about eye." The note indicated nursing staff reported overall improvement after stopping Aricept (treat confusion) and adding Seroquel 12.5 mg in the afternoon. The Assessment & Plan included, "Noting improvement with medication changes that we have made in the past no other changes at this time." Also included in the plan were sections	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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01820	Continued From page 30 titled "Orders Placed" and "Medication Changes," to which were marked as "none." The Medication List at End of Visit included Quetiapine (same as Seroquel) 25 mg once daily, take 1/2 tab (12.5 mg) once daily as needed; however, did not include an order to continue the scheduled Seroquel 12.5 mg daily, in the afternoon. R1's Med Admin [administration] Summary, dated March 2022, included "Quetiapine 25Mg Tablet (Daily). Take half tablet (12.5 mg total) by mouth in the afternoon daily; trial for 2 weeks to see if any improvement happens (Starts: 03/30 03:00 PM)." The same order remained on the April 2022 Med Admin Summary, with initials to indicate the medication was given from April 1, 2022, through April 30, 2022, and on the May 2022 Med Admin Summary, with initials to indicate the medication was given from May 1, 2022, through May 18, 2022. R1's record lacked an order to continue the Seroquel after the 14-day trial period. During an interview on May 19, 2022, at 10:45 a.m., registered nurse (RN)-B acknowledged prescriber orders for R1 lacked an order to continue the Seroquel. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy, undated, indicated the RN was responsible for assuring that current, authorized prescriber prescriptions for medications to be administered by the staff are kept in the resident's record and that changes in orders are addressed in the resident's care plan, service plan and Medication Administration Record, and are communicated on a timely basis to all appropriate staff. No further information was provided.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01820	Continued From page 31 TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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02040	Continued From page 32 A record review and interview were conducted on May 19, 2022, at approximately 1:40 p.m. with Lead Care Manager (LCM)-F on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LCM-F stated that licensee had conducted a hazard vulnerability assessment for the emergency disaster plan for the facility but had not conducted a hazard vulnerability assessment of the physical environment with mitigation factors on and around the property to date at the time of survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for eight of eight residents (R5, R6, R7, R8, R9, R10, R11, R12) with siderails.	02310	On May 18, 2022, the immediacy of correction order 2310 was removed, however non-compliance remains at a level 3, widespread.	

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	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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02310	Continued From page 33 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R5 On May 17, 2022, at approximately 1:36 p.m., the surveyor observed registered nurse (RN)-B measure R5's bilateral siderails, which were affixed to the bed. R5 was not able to describe her usage of the siderails. The siderails were metal, had eight vertical bars with nine openings. The openings between the bars for zone 1 varied, with the largest opening measuring 3 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured 2.875 inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 3.625 inches. R5 had diagnoses including vascular dementia, traumatic brain injury, frequent urination at night and abnormality of gait. R5's medical record included Resident Profile, printed May 17, 2022, indicated R5's services included grooming, behavior monitoring, shower assistance, safety checks every two hours, toileting, meals, laundry and housekeeping. R5's medical record included education of the	02310		

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	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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02310	Continued From page 34 risks and benefits associated with the use of siderails, signed by R5's power of attorney (POA) on March 11, 2022. R5's medical record included Master Care Plan, dated March 29, 2022, indicated R5's siderails were per request of resident and/or family and aided in transfers to and from bed, and turning and repositioning. RN-B reviewed the guide to bed safety with R5 and family and indicated the siderail met the requirements set by the Food and Drug Administration (FDA); however, lacked documentation of a siderail assessment to include measurements. R6 On May 17, 2022, at approximately 1:41 p.m., the surveyor observed RN-B measure R6's siderail on the left side of the bed. The white metal pole measured 36 1/2" high and was affixed to a wood-type platform measuring 3 feet x 2 feet. The platform was slid between the mattress and the frame of the twin sized bed, was not anchored to the frame of the bed in any way and easily moved when pulling on it. R6 described using the pole to grasp when sitting up in bed in the morning. The measurements between the mattress and the siderail for zone 3, measured 1.25 inches; however, the gap increased when the siderail was gently pulled. Also, the bed had no headboard, therefore, the measurement between the rail to the wall at the head of the bed for zone 6 measured 15 inches. R6 had diagnoses including multiple sclerosis (MS), stroke, mild cognitive impairment and restless leg syndrome. R6's medical record included Resident Profile, printed May 17, 2022, indicated R6's services	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 35 included assistance with dressing and grooming, behavior monitoring, meals, toileting, wellbeing checks every two hours, laundry and housekeeping. R6's Resident Notes-One Resident, dated October 26, 2021, indicated R6 had used the pole for many years to get in and out of bed, the pole had no openings and was secured to a wood platform that slid under the mattress. R6's medical record included Master Care Plan, updated May 6, 2022, which indicated R6's siderail was a straight pole with no gaps, was under the mattress of the twin bed, and R6 used it to get in and out of bed. R6's record lacked documentation of a siderail assessment to include measurements and lacked education of the risks and benefits associated with the use of siderail. R7 On May 17, 2022, at approximately 1:58 p.m., the surveyor observed RN-B measure R7's siderail on the left side of the bed. RN-B stated R7 received this siderail recently. The siderail consisted of a single black painted metal pipe in the shape of an upside down elongated "U" with metal arms extending between the mattress and the box frame. Straps anchored the device to the opposite side of the bed. The measurements within the opening of the siderail for zone 1, measured 12 inches, and a black cover was in place to cover most of the opening, leaving two inches open at the top of the side rail. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The bed had no headboard, therefore, measurements between the rail to the wall at the head of the bed for zone 6, measured 16 inches.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 36 R7 had diagnoses including myotonic disorder (form of muscular dystrophy), weakness, social anxiety and depression. R7's medical record included Resident Profile, printed May 17, 2022, indicated R7's services included behavior monitoring, meals, shower assistance, transfer assist of two, wellbeing checks every two hours, laundry and housekeeping. R7's Resident Notes-One Resident, dated April 26, 2022, indicated R7 had received a new siderail on this date and documented measurements including top to bottom and side to side; however, did not include appropriate measurements of the applicable zones per FDA guidelines. R7's medical record included Master Care Plan, updated March 11, 2022, indicated R7 used their siderail to assist with transfers to and from bed and to aid in turning and repositioning. The care plan indicated R7 had reviewed and signed "A Guide to Bed Safety," and a side rail use assessment had been completed; however, R7's record lacked documentation of a siderail assessment to include measurements. R8 On May 17, 2022, at approximately 1:30 p.m., the surveyor observed RN-B measure R8's siderail on the right side of the bed. R8 stated she used the siderail to get in and out of bed. The siderail consisted of a single white painted metal pipe in the shape of an upside-down squared corner "U" with one horizontal bar across the top third of the rail and was bolted to a 24-inch wooden board that slid under the mattress and was not secured	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 37 to the bed. The measurements within the opening of the siderail for zone 1, measured 3.875 x 6.375 inches. The measurements under the rail, between the rail support for zone 2, measured 4 inches. The measurements between the mattress and the bedrail for zone 3, measured 1.75 inches. The measurements between the end of the rail and the side edge of the headboard for zone 6, was 19 3/4 inches. R8 had diagnoses including Parkinson's Disease, knee joint replacement, morbid obesity, and adjustment disorder with mixed anxiety and depression. R8's medical record included Resident Profile, printed May 17, 2022, indicated R8's services included behavior monitoring, meals, shower assistance, toileting, dressing, grooming, wellbeing checks every two hours, laundry and housekeeping. R8's Resident Notes-One Resident, dated April 4, 2022, indicated measurements including top to bottom and across openings; however, did not include appropriate measurements of the applicable zones per FDA guidelines. R8's medical record included Master Care Plan, updated April 13, 2022, indicated R8's siderail was specifically requested by resident and/or family. R8 used the siderail to assist with transfers to and from bed and to aid in turning and repositioning. The care plan indicated the siderail was appropriate based upon assessed need; however, R8's record lacked documentation of a siderail assessment to include measurements and lacked education of the risks and benefits associated with the use of siderail.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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02310	Continued From page 38 R9 On May 17, 2022, at approximately 1:45 p.m., the surveyor observed RN-B measure R9's siderail on the left side of a full-sized bed. RN-B stated R9 was independent and didn't use the siderail often. The siderail consisted of a single white painted metal pipe in the shape of a backwards "D" and was affixed to a metal platform that slid between the mattress and the frame. The metal platform was not secured to the bed. The siderail rested against the side of the bed; however, swung out and away from the mattress when pushed. The measurements within the opening of the siderail for zone 1, measured 5 1/2 x 10 inches, and a cloth cover was placed over the opening. The measurements under the rail, between the rail support for zone 2, measured 0 inches. The measurements between the mattress and the bedrail for zone 3, measured 2 inches. The measurements between the end of the rail and the side edge of the headboard for zone 6, was 16 inches. R9 had diagnoses including stroke, tremor, seizures, and ataxia (impaired coordination). R9's medical record included Resident Profile, printed May 17, 2022, indicated R9's services included dressing, grooming, behavior monitoring, meals, shower assistance, toileting, wellbeing checks every two hours, laundry and housekeeping. R9's Resident Notes-One Resident, dated November 1, 2021, indicated measurements of "gap is 6.5 inches," and included R9 was notified that the gap did not meet the requirements. Family planned to provide a covering for the area or a new siderail. Also noted, the siderail "does	02310		

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	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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02310	Continued From page 39 swivel from side to side, resident safely uses it to get in and out of bed and denies having any trouble." Another note, dated April 6, 2022 (five months later), indicated the siderail did not meet requirements for safety in terms of gaps, discussed a cover, a new siderail, or to take this rail out. R9 stated she hardly used the siderail but would see if she could find a cover. R9's medical record included Master Care Plan, updated May 16, 2022, incorrectly indicated R9 had bilateral siderails that assisted R9 with transfers to and from bed and to aid in turning and repositioning. The care plan indicated the siderail opening measurements were appropriate and met the requirements set by the FDA. R9's record lacked documentation of a siderail assessment to include measurements. R10 On May 17, 2022, at approximately 2:03 p.m., the surveyor observed RN-B measure R10's bilateral metal siderails, which were affixed to the bed. The right siderail was in the raised position, and the left siderail was in the lowered position. R10 was lying in the bed on his stomach. R10 stated he liked to have both siderails up at night and stated he used them to turn over and to get up. The siderails had six vertical bars with seven openings. The openings between the bars for zone 1 varied, with the largest opening measuring 4.625 inches. The measurements between the mattress and the bedrail for zone 3, measured 1 inch on the left and 0 inches on the right. The measurements between the top of the rail to the head of bed for zone 6, measured 18.5 inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 5 inches.	02310		

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	29913	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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02310	Continued From page 40 R10 had diagnoses including moderate dementia, transient ischemic attack (mini stroke), macular degeneration (visual impairment), and peripheral neuropathy (weakness and numbness in feet and hands). R10's medical record included Resident Profile, printed May 17, 2022, indicated R10's services included behavior monitoring, meals, shower assistance, toileting, dressing, grooming, wellbeing checks every two hours, laundry and housekeeping. R10's medical record included Master Care Plan, updated May 12, 2022, indicated R10's bilateral siderails assisted R10 with transfers to and from bed and aided in turning and repositioning, and indicated the siderails were appropriate based upon assessed need; however, R10's record lacked documentation of a siderail assessment to include measurements. R11 On May 17, 2022, at approximately 2:30 p.m., the surveyor observed RN-B measure R11's bilateral metal siderails, which were affixed to the bed. The right siderail was in the raised position, and the left siderail was in the lowered position. R11 stated she liked to have both siderails up at night and stated she used them to turn over and to get up. The siderails had eight vertical bars with nine openings. The openings between the bars for zone 1 varied, with the largest opening measuring 3 3/8 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured 2 5/8 inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 3 inches.	02310		

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02310	Continued From page 41 R11 had diagnoses including dementia, confusion, and sensory peripheral neuropathy. R11's medical record included Resident Profile, printed May 17, 2022, indicated R11's services included behavior monitoring, meals, shower assistance, toileting, dressing, grooming, wellbeing checks every two hours, laundry and housekeeping. R11's Resident Notes-One Resident, dated April 18, 2022, indicated the siderails were delivered and installed by a medical equipment company. R11's medical record included Master Care Plan, updated February 21, 2022, lacked information regarding R11's siderails. R11's record lacked documentation of a siderail assessment to include measurements and lacked education of the risks and benefits associated with the use of siderail. R12 On May 17, 2022, at approximately 1:18 p.m., the surveyor observed RN-B measure R12's siderail on the right side of the bed. R12 stated she used the rail to get into bed and to turn over. The siderail consisted of a single black painted metal pipe in the shape of an elongated "C" with the opening at the bottom. The siderail was bolted to a wood platform that slid between the mattress and the frame. The platform was not secured to the bed. The measurements within the opening of the siderail for zone 1, measured 12 x 5.75 inches, and a black vinyl-like cover was placed over the opening. The measurements under the rail, between the rail support for zone 2, measured 2 inches. The measurements between the mattress and the bedrail for zone 3,	02310		

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02310	Continued From page 42	02310		

measured 0 inches. The measurements between the end of the rail and the side edge of the headboard for zone 6, was 12 inches.

R12 had diagnoses including history of stroke and syncope (fainting).

R12's medical record included Resident Profile, printed May 17, 2022, indicated R12's services included meals, shower assistance, toileting, dressing, grooming, wellbeing checks every two hours, laundry and housekeeping.

R12's Resident Notes-One Resident, dated May 11, 2022, indicated the siderails were provided by occupational therapy (OT) and deemed safe to use per OT and RN. The note included measurements of the opening of the siderail and from the siderail to the head of the bed; however, did not include appropriate measurements of the applicable zones per FDA guidelines.

R12's medical record included Master Care Plan, updated March 4, 2022, included the siderail was appropriate based upon assessed need including fall prevention, aid in transfers to and from bed, and aid in turning and repositioning; however, R12's record lacked documentation of a siderail assessment to include measurements, and lacked education of the risks and benefits associated with the use of siderail.

On May 17, 2022, at approximately 3:15 p.m., RN-B stated the siderail assessment included in the residents' Master Care Plan, did not include measurements. RN-B stated she would take a picture of the siderails and would measure the openings between the rails but was not aware of the FDA requirements to measure the zones to ensure the safe use of the siderails. RN-B stated

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02310	Continued From page 43 some of the residents had been provided the education of the risks and benefits, but not everyone. The licensee's Assessing the Safety of Side Rails policy, undated, indicated the RN would assess and evaluate what the resident's needs were and assess to determine if the resident could safely utilize the side rail/equipment and determine whether it met the FDA standards for siderails. The RN would educate the resident, the resident's representative and/or family members about the risks related to siderails, and if the resident's siderail did not appear to meet FDA standards, the RN would recommend that the siderail be removed and would recommend alternative options to reduce the risk of a fall out of bed. The RN would document the conversations and recommendations. The policy did not address documenting measurements according to the FDA guidelines. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems	02310		

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02310	Continued From page 44 with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or	02410		

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02410	Continued From page 45 assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the right to respect and privacy for five of five residents (R13, R14, R15, R16, R17) with regards to displaying protected health information. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on May 16, 2022, at approximately 1:45 p.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B stated five residents in the secured memory care unit were COVID-19 positive and were quarantined in their rooms. On May 17, 2022, at approximately 11:30 a.m., the surveyor observed five residents' room doors in the secured memory care unit had an 8 x 11 inch sign that indicated the resident was "COVID-19 Positive" and indicated dates of quarantine. Also included, "PPE [personal protective equipment] REQUIRED." R13 had diagnoses including Alzheimer's dementia and was diagnosed with COVID-19 on May 16, 2022.	02410		

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02410	Continued From page 46 R14 had diagnoses including Alzheimer's dementia and was diagnosed with COVID-19 on May 16, 2022. R15 had diagnoses including dementia and was diagnosed with COVID-19 on May 16, 2022. R16 had diagnoses including dementia and was diagnosed with COVID-19 on May 16, 2022. R17 had diagnoses including dementia and was diagnosed with COVID-19 on May 9, 2022. On May 19, 2022, at approximately 11:20 a.m., RN-B indicated the signs on the residents' room doors did not ensure their personal and treatment privacy and would be removed. The licensee's Resident Rights policy, undated, indicated residents have the right to respect and privacy regarding the resident's care and treatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *05/17/22*
Time: 13:30:07
Report: 1028221077

Food and Beverage Establishment Inspection Report

Location:
Woodstone Senior Living
2020 Meyer Drive
New Ulm, MN56073
Brown County, 08

Establishment Info:
ID #: 0039100
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073593355
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

Deli ham in the refrigerator marked 05/09/22 must be discarded as it has passed 7 days since opening.

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: -16 Degrees Fahrenheit - Location: Beverage Air freezer
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Ham
Violation Issued: No

Type: Full
Date: *05/17/22*
Time: 13:30:07
Report: 1028221077
Woodstone Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: Beverage Air refrigerator
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	0

This Inspection was conducted in conjunction with HRD.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221077 of 05/17/22.

Certified Food Protection Manager: Marianne Case

Certification Number: FM85507 Expires: 08/23/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
Brittany Gulden
Director

Signed: _____
Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us