



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 13, 2025

Administrator
WOODBURY HEALTH CARE CENTER

7012 LAKE ROAD
WOODBURY, MN 55125

RE: CCN:245235

Cycle Start Date: July 24, 2025

Dear Administrator:

On July 24, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 24, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by

the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 24, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies. A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

**Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145**

St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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Administrator

WOODBURY HEALTH CARE CENTER

7012 LAKE ROAD

WOODBURY, MN 55125

Re: State Nursing Home Licensing Orders

Event ID: D6YU11

Dear Administrator:

The above facility was surveyed on July 24, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2025	
NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD , WOODBURY, Minnesota, 55125			
(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) COMPLETION DATE	
E0000	Initial Comments On 7/21/25 through 7/24/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			09/08/2025	
F0000	INITIAL COMMENTS On 7/21/25 through 7/24/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiencies cited: H52359827C (MN00114238) H52357308C (MN00113866) H52359844C (MN00111361) H52359828C (MN00110944) H52359829C (MN00109552) H52359830C (MN00105523) H52351060C (2568505) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.		F0000			10/01/2025	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0000 F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self administration of medications (SAM) was completed to allow residents to safely administer their own medications for 1 of 1 resident (R68) observed with a medication at the bedside. R68's Medical Diagnosis form indicated the following diagnoses: acute and chronic respiratory failure with hypoxia, severe persistent asthma, chronic obstructive pulmonary disease with acute exacerbation, and emphysema. R68's quarterly Minimum Data Set (MDS) dated 6/26/25, indicated intact cognition, and had shortness of breath with exertion when sitting at rest, and when lying flat. R68's care plan dated 4/3/25 indicated R68 could not self-administer medications and nebulizers, and the facility was to administer medications as resident was not safe to independently administer medications at this time. Additionally, a SAM was to be completed quarterly and as needed. R68's physician orders form indicated the following orders:3/23/25, and discontinued on 7/22/25, Albuterol Sulfate HFA inhalation aerosol solution 108 (90 Base) microgram (MCG)/ACT inhaler inhale 1 puff orally every 4 hours as needed for wheezing. Inhale 1-2 puffs into the lungs to be administered by the clinician.7/22/25, Albuterol Sulfate HFA inhalation aerosol solution 108 (90 base) mcg/ACT 2 puffs inhale orally every 4 hours as needed for wheezing to be administered by the clinician. R68's medication administration record (MAR) and treatment administration record (TAR) dated July 2025, lacked information R68 utilized as needed Albuterol. R68's MAR and TAR lacked information R68 could SAM her Albuterol metered dose inhaler (MDI). R68's Self Administration of Nebulizers Evaluation form dated 4/3/25, indicated R68 had a physician's order to self-administer nebulizers and could be left along	F0000 F0554	F0554 – Self-Administration of Medications (SAM): The facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow residents to safely administer their own medications for 1 of 1 resident (R68) observed with a medication at the bedside. The alleged deficiencies for resident R68 have been corrected as of 7/23/2025 Interventions Implemented: R68's Albuterol MDI was immediately removed from the bedside. A comprehensive SAM assessment was completed for R68 regarding her ability to self-administer Albuterol MDI on 7/28/2025. The physician was notified, and an updated order was obtained to clarify whether R68 may self-administer her Albuterol MDI. R68's care plan and MAR/TAR is updated to reflect current status. Immediate education was provided to nursing staff on the requirements for SAM assessments and orders prior to allowing medications at the bedside. The Director of Nursing (DON) was responsible for implementing these corrections. Residents who self-administer medications or have medications at the bedside have the potential to be affected by the alleged deficient practice. The DON has completed audits of all residents with medications at the bedside and those with current or recent SAM orders as of July 24th, 2025 to ensure no other residents were affected. Any discrepancies were addressed immediately, including completion of SAM assessments and obtaining appropriate provider orders. The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: A new audit tool was implemented on 8/12/2025 to track all residents with medications at the bedside and ensure compliance with assessment and order requirements. Education will be provided for all licensed nursing staff regarding the protocol for SAM. This education will be completed by the compliance date noted below. On-call or PRN staff not working during this period will receive training prior to their next scheduled shift.	10/01/2025

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F0554 SS = D	Continued from page 2 during administration of nebulizer treatment. The form lacked information whether R68 could self-administer her Albuterol MDI. R68's nursing progress notes were reviewed and lacked information R68 could SAM her Albuterol MDI. During observation on 7/21/25 at 1:25 p.m., R68 had an Albuterol inhaler on the bedside table in her room and stated she used the inhaler. During observation on 7/23/25 at 7:14 a.m., R68 had an inhaler on her bedside table. During observation on 7/23/25 at 8:22 a.m., an unknown staff person entered R68's room and delivered her meal and left the room. During observation on 7/23/25 at 8:25 a.m., nursing assistant (NA)-A entered R68's room and placed a packet of butter on the bedside table and left to get R68 a spoon. R68 had the albuterol inhaler with an open date of 12/27 written on the label. At 8:26 a.m., NA-A entered the room to assist R68 with her bed and left the room. During interview and observation on 7/23/25 at 9:10 a.m., licensed practical nurse (LPN)-A entered R68's room and moved R68's meal tray off the bedside table and started R68's nebulizer. At 9:11 a.m., LPN-A left the room with the meal tray. LPN-A stated a few residents can have medications at the bedside and stated those residents had an order to do so and they also have an assessment to make sure they are alert and oriented and further stated for inhalers to be self-administered, staff had to make sure residents understood to how to breathe into the inhaler and take two puffs and stated the technique differed from a nebulizer. LPN-A viewed R68's orders for her Albuterol inhaler and verified the medication was supposed to be administered by the clinician and verified R68's Albuterol inhaler was located on her bedside table and stated that was something that could be followed up on and stated there needed to be an order and stated he looked to the MAR to know if a resident could SAM. During interview on 7/23/25 at 9:24 a.m., LPN-B viewed R68's orders in the paper chart and stated R68 had an order to SAM nebulizers but did not have an order to SAM the Albuterol MDI. During interview on 7/23/25 at 9:28 a.m. with registered nurse (RN)-B and LPN-B, RN-B viewed R68's paper chart and both RN-B and LPN-B stated R68 should			F0554	Continued from page 2 Facility will monitor performance to ensure sustained compliance. The DON or designee will audit all residents with medications at the bedside and review SAM assessments and orders weekly for a minimum of 1 month until 4 weeks of consecutive compliance is met. Audit results will be presented to the QAPI committee, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. Facility will be in substantial compliance by 10/01/2025		

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F0554 SS = D	Continued from page 3 have a SAM assessment for the Albuterol MDI in addition to her assessment for nebulizers. LPN-B stated if a resident had a nebulizer the nurse had to assess if the resident could keep the mask on and if a resident had an MDI the nurse had to educate the resident on how many puffs they can take and watch them and document if they are able to know the frequency and both RN-B and LPN-B verified R68 did not have a SAM assessment for an MDI, and did not have an order to SAM the Albuterol MDI. During interview on 7/23/25 at 10:41 a.m., the director of nursing (DON) stated if a resident wanted to self-administer their medications, a SAM assessment would be completed, and an order would be obtained from the provider and further stated she expected MDIs would not be kept at the bedside unless it was determined the resident was safe to SAM. A policy, Medication Self Administration Safety Screen and/or Self Administration dated 9/2023, indicated the Medication Self Administration Safety Screen and/or the Self Administration of Nebulizer's Evaluation is only completed if the resident requests to do their own medications or some of their own medications such as inhalers, eye drops or actual pills. Evaluation and approval for self-administration of medications will be based on the Medication Self-Administration Safety Screen and or the Self-Administration of Nebulizer's Evaluation. The IDT will review the summary on the Medication Self-Administration Safety Screen to determine appropriateness of self-administration of medications. The determination will include whether the resident can self-administer medications unsupervised, with supervision or is not safe to administer medications. A physician order will be obtained indicating which medications the resident may self-administer and with or without supervision.	F0554		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F0578	F0578 – Advance Directives/CPR: Documentation Consistency • The alleged deficiencies for resident(s) R87 have been corrected as of 07/22/2025. The POLST for R87 was immediately reviewed and corrected to accurately reflect the resident's wishes for Do Not Resuscitate (DNR), consistent with the face sheet and physician's orders. The resident was re-interviewed to confirm code status, and a new POLST was completed and signed. Immediate education was provided to the involved nursing staff regarding the importance of accurate and	10/01/2025

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F0578 SS = D	Continued from page 4 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure a resident's wishes for resuscitation were accurately documented in all areas the medical record for 1 of 22 residents (R87) reviewed for advanced directives. R87's quarterly Minimum Data Set (MDS) dated 5/22/25, indicated moderately impaired cognition and diagnoses of Ehlers-Danlos Syndrome, signs and symptoms involving cognitive function and awareness, and Chronic Obstructive Pulmonary Disease (COPD). It further indicated R87 required supervision with activities of daily living (ADL) and was independent with mobility. R87's face sheet/banner in Point Click Care (computer system for documentation) indicated Do Not Resuscitate (DNR). R87's physician's orders indicated DNR. R87's Physician's Order for Life Sustaining Treatment (POLST) dated 11/15/25, indicated Cardiopulmonary Resuscitation (CPR) and DNR. During interview on 7/21/25 at 6:22 p.m., R87 stated she did not want life saving measures and "there comes a point	F0578	Continued from page 4 consistent documentation of advance directives. The Director of Nursing (DON) was responsible for implementing these corrections. - Residents who have advance directives or code status orders have the potential to be affected by the alleged deficient practice. The DON has completed an audit of all current residents' medical records, including POLST forms, and physician orders, as of 07/22/2025, to ensure consistency and accuracy of code status documentation. No additional discrepancies were identified during this audit. - The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: All licensed nursing staff will be re-educated by 09/12/2025 regarding: The process for completing and updating POLST forms. The requirement for consistency across all areas of the medical record (POLST and physician orders). The procedure for correcting errors on POLST forms (voiding incorrect forms and obtaining new signatures). The importance of immediately clarifying any discrepancies with the resident, responsible party, and physician. The "Advance Directives and Code Status" policy was reviewed as of 07/30/2025 to clarify: Steps for verifying and documenting code status. The process for resolving discrepancies. Documentation requirements for all changes or clarifications.	

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NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD , WOODBURY, Minnesota, 55125			
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F0578 SS = D	Continued from page 5 in your life where you don't want to be filled with junk anymore so when your time comes, it comes." During interview on 7/21/25 6:30 p.m., registered nurse (RN)-A stated if a resident was found unresponsive, the first place they would look for their code status would be on the POLST. If the POLST indicated both CPR and DNR, they would "error on the said of caution" and perform CPR. RN-A further stated if a nurse made an error when filling out the POLST, they should get a new one and start over because it was a very important document. During interview on 7/21/25 at 7:05 p.m., licensed practical nurse (LPN)-C stated if a resident was found unresponsive, the first place they would look for their code status would be on the POLST. If the POLST indicated CPR and DNR or there was a discrepancy, they would get clarification from the nurse manager on what should be done. LPN-C further stated if they made an error while filling out a residents POLST, they would get a new one and have the resident/resident representative re-sign it. During interview on 7/21/25 at 7:55 p.m., LPN-D stated if a resident was found unresponsive, the first place they would go to check their code status was the POLST. The POLST shouldn't indicate CPR and DNR because a physician goes over it, however if it did indicate both options, they would clarify it with the resident or their responsible party in order to determine what to do next. During interview on 7/21/2025 at 7:52 p.m., LPN-E stated if a resident was found unresponsive, the first place they would look for their code status would be on the POLST. If there was a discrepancy, they would get clarification from the nurse manager/supervisor on what to do. During interview on 7/23/25 at 11:45 a.m., the nurse manager RN-C stated if a resident became unresponsive, the first place they would look to find their code status would be on the face sheet/banner in PCC because if they are at the cart, it's the closest place to look. RN-C would also encourage the nurses to look at the residents POLST in order to compare the face sheet/banner to the POLST. If the POLST indicated CPR and DNR, then the nurse should compare it to the banner in PCC. If there was a discrepancy or staff had a question, they should clarify it with the nurse manager/supervisor in order to know how to proceed. During interview on 7/24/25 at 12:34 p.m., the director of nursing (DON) stated if a resident became unresponsive, the first place nurses would look to find their code status would be on their POLST. There was also an order in PCC with a banner/ribbon that should match. If there was a discrepancy, they should look at dates to see which one was the most recent. They should also do a quick comparison. If family was easily		F0578	Continued from page 5 • Facility will monitor performance to ensure sustained compliance. The DON or designee will audit 100% of new admissions and 10% of current residents' records for code status documentation consistency weekly for 4 weeks until 4 weeks of consecutive 100% compliance has been obtained. Audit results will be presented to the QAPI committee monthly, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. Facility will be in substantial compliance by 10/01/2025.			

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F0578 SS = D	Continued from page 6 reachable, the nurses could contact them as well. If the POLST indicated both CPR and DNR, the nurse should compare it to the face sheet/banner in PCC. If the nurse makes an error on POLST, they should get a new POLST. This was important because "it leaves it open to too much interpretation when we get messy like that." The facility policy regarding advanced directives dated 12/2018, indicated when the need for resuscitation occurs, the physician order status, and/or (CPR) Resuscitate/Do not Resuscitate decision in Part 2 of the Health Care Directive and/or Part A of the POLST will be followed and then the physician will be notified as soon as possible.	F0578		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by:	F0657	The alleged deficiencies for resident R50 have been corrected as of August 19, 2025. The resident's care conference was immediately scheduled and conducted with both the residents and family invited and present. The care plan was reviewed and updated by the interdisciplinary team. Immediate education was provided to all applicable IDT members regarding timely scheduling and documentation of care conferences 8/18/25. The Director of Social Services was responsible for implementing the corrections. The Director of Social Services, or designee performed a full house audit of care conferences in accordance with the Care Conference policy and deficiencies found in the last quarter were scheduled/offered a care conference by 8/29/25. A tracking log for care conferences has been reviewed to ensure timely scheduling and documentation of all required care conferences. IDT will be educated on each department's care conference assessment requirements. The Director of Social Services or designee will audit Care conference completion and compliance of 100% of long-term care residents for a minimum of 1 month until 4 weeks of 100% compliance has been met consecutively. Audits will be reviewed at the monthly QAPI meeting to discuss trends, patterns and continued recommendations for process and monitoring and continued compliance. Facility will be in compliance by 10/1/25.	10/01/2025

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F0657 SS = D	Continued from page 7 Based on interview and document review, the facility failed to provide routine care conferences to allow for resident/ family participation and interdisciplinary review, and update, if necessary, of the care plan for 1 of 1 resident (R50) reviewed for care conferences. Findings include: R 50's quarterly Minimum Data Set (MDS) dated 6/16/25 severely cognitively impaired, unable to communicate clearly, and understand others. R50 had the following diagnoses: major depressive disorder, Alzheimer's, unspecified psychosis not due to a substance or known physiological condition, unspecified dementia, psychotic disturbance, mood disturbance, and anxiety. R50's electronic medical record (EMR) indicated R50 had a care conference on 6/24/25, EMR indicated the last documented care conference for R50 was 10/7/24. During an interview on 7/21/25 at 6:28 p.m., R50's family member (FM)-A stated the facility were doing care conferences quarterly then it changed. FM-A stated it was explained to them the social worker left the facility, so no care conferences were offered. FM-A wanted to be included in care conferences and give input for care plan of R50. During an interview on 7/24/25 at 11:48 a.m., LPN manager (LPN)-A stated the care conferences and care plan review were held quarterly, annually, if changes occur, staff or family request. The expectation was informing resident, family, dietary, physical, occupational and speech therapy, speech, social services, community life, nurses, doctors, director of nurses and executive director to attend care conference. During an interview on 7/24/25 at 12:16 p.m., the director of social services (SS)-A stated the expectations for care conferences and care plan review were held quarterly, annually, and if requested. The care conference and care plan were correlated with the MDS. The expectation was informing resident, family, dietary, physical, occupational and speech therapy, , social services, community life, nurses, doctors, director of nurses and executive director to attend care conference. The importance of care conferences was to collaborate across disciplines, provide comprehensive assessments, meet the psychosocial needs of residents and families and provide resources. During an interview on 7/24/25 at 3:14 p.m., the	F0657		

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F0657 SS = D	Continued from page 8 director of nurses (DON)-A stated the process for care conferences were to be done upon admit, quarterly and annually. The care plans and care conferences are assessed in the same time frame. The expectations for care conferences were to collaborate with family and resident and address any concerns. The family, resident and members of the interdisciplinary team (IDT) were informed of the time and date of care conference. The importance and individualized care plans are through care conferences, the collaboration with family and resident learn about them, how they grow and meet their needs at their level. A facility policy titled Care Conferences stated the care conference guidelines indicated the IDT would review and update after: · *Initial: Complete Care Conference after admission MDS, CAAs, care plan was completed · Quarterly · Discharge Planning · Change in condition As needed for any resident and/or family request	F0657		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to ensure symptoms of constipation were acted upon and assessed to determine what, if any interventions were needed to promote appropriate bowel management for 1 of 1 resident (R4). Findings include: R4's Optional State Assessment (OSA) dated 7/8/25, indicated R4 did not reject care, required extensive	F0684	F0684 – Quality of Care: Bowel Management and Constipation Assessment Tag Number & Description: F0684 – The facility failed to ensure symptoms of constipation were acted upon and assessed to determine what, if any, interventions were needed to promote appropriate bowel management for 1 of 1 resident (R4). The alleged deficiencies for resident R4 have been corrected as of July 24, 2025. The resident's bowel status was immediately reassessed, and an individualized bowel management plan was adjusted, including physician notification, and monitoring of bowel movements. Immediate education was provided to the nursing managers regarding prompt review and reporting of constipation symptoms. The Director of Nursing (DON) was responsible for implementing these corrections. Residents who are at risk for constipation or have a history of bowel management issues have the potential to be affected by the alleged deficient practice. The DON has completed audits of all residents who have not had a bowel movement in 3 days or greater as of July	10/01/2025

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F0684 SS = D	Continued from page 9 assistance with bed mobility and toilet use, and was not on a urinary or bowel toileting program. R4's Medical Diagnosis form indicated the following diagnoses: hemiplegia (paralysis of one side of the body) affecting the left nondominant side, diabetes mellitus (DM), muscle weakness, chronic idiopathic (without a known cause) constipation. R4's care plan dated 10/3/24 indicated R4 had a self care deficit due to a stroke and required substantial to maximal assist of one for personal hygiene. R4's care plan dated 7/17/25 indicated R4 refused to get out of bed due to refusing the mechanical lift. R4's care plan dated 10/14/24, indicated R4 had frequent incontinence of bowel and bladder and interventions indicated to record bowel movements daily and used a bed pan and urinal. R4's care plan dated 7/8/25, indicated R4 had a nutrition problem due to diagnoses that included constipation. R4's physician's orders form indicated the following orders: 4/24/25, senna-docusate sodium (stool softener) oral tablet 8.6-50 milligram (MG) tablet, give one tablet twice a day.4/24/25, bisacodyl rectal suppository (a laxative) 10 mg, insert 10 mg rectally every 72 hours as needed for constipation.R4's medication administration record (MAR) and treatment administration record (TAR) dated June 2025, indicated R4 received senna-docusate sodium twice daily. Further, R4 did not utilize any PRN bisacodyl medication. R4's MAR and TAR dated July 2025, and saved 7/24/25 at 7:08 a.m., indicated R4 received senna-docusate sodium twice daily. Further, R4 did not utilize any PRN bisacodyl medication. R4's Task form titled, Bowel Continence & BM, dated 5/26/25, to 7/24/25, indicated the following:On 6/13/25 at 2:22 p.m., R4 had a large bowel movement. No further bowel movements were documented until 6/18/25 at 7:42 p.m., when R4 had a large bowel movement. On 6/18/25 at 7:42 p.m., R4 had a large bowel movement. No further bowel movements were documented until 6/22/25 at 9:49 p.m., when R4 had a medium bowel movement.On 6/23/25 at 7:40 p.m., R4 had a large bowel movement. No further bowel movements were documented until 6/27/25 at 5:55 a.m., when R4 had a medium bowel movement. On 7/1/25 at 8:16 p.m., R4 had a large bowel movement.		F0684	Continued from page 9 28, 2025, to ensure no other residents were affected. Systemic Measures and Changes The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: All licensed nursing staff will be re-educated by 9/12/25 on the facility's Bowel Management and Constipation protocol, including timely assessment, documentation, and intervention protocols. A Bowel Movement Monitoring Tool was reviewed on July 28, 2025, to ensure daily tracking and prompt identification of constipation symptoms. The DON/designee will review all new admissions and current residents 5 days/week for symptoms of constipation. Monitoring and Quality Assurance Facility will monitor performance to ensure sustained compliance. The DON or designee will audit bowel movement documentation and intervention for all residents at risk for constipation twice weekly for a minimum of 1 month until 4 weeks of 100% consistent compliance is met with appropriate intervention. Audit results will be presented to the QAPI committee, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. Facility will be in substantial compliance by 10/01/2025			

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F0684 SS = D	Continued from page 10 No further bowel movements were documented until 7/6/25 at 2:41 p.m., when R4 had a large bowel movement. On 7/8/25 at 12:34 p.m., R4 had a large bowel movement. No further bowel movements were documented until 7/14/25 at 2:29 p.m., when R4 had a large bowel movement. On 7/17/25 at 9:26 p.m., R4 had a medium bowel movement. No further bowel movements were documented until 7/21/25 at 9:45 p.m., when R4 had a small bowel movement. R4's nursing progress notes were reviewed from 5/26/25, to 7/23/25, and lacked information R4 was administered as needed bisacodyl if R4 had no bowel movement for 72 hours. Further, progress notes lacked physician notification during days R4 went longer than 72 hours without a bowel movement. Progress notes lacked information R4 was going longer than 72 hours without having a bowel movement. R4's Comprehensive Nursing Data Collection form dated 7/2/25, indicated R4 was alert and oriented to person, place, time, and situation, had frequent bladder incontinence, and was continent of bowels. Further, R4's bowel sounds were present and active, had a soft and rounded abdomen, and under a heading, "Date of last BM" indicated, "see CNA task". During interview and observation on 7/21/25 between 12:44 p.m., and 12:51 p.m., R4 was in his bed and stated he hadn't gone to the bathroom in 5 days and stated he felt some movement, but the stool did not want to come and added this was an everyday concern. R4 stated staff provided a bedpan and stated he asked about Miralax (a medication to treat constipation) which he stated sometimes helped and prune juice and added it was very uncomfortable. R4 stated his normal pattern was every other day not every 5 days. During interview on 7/24/25 at 9:44 a.m., licensed practical nurse (LPN)-B stated refusals were documented in a progress note and staff documented bowel movements in the Tasks form where the nursing assistants (NA) document the size of the bowel movement and the NA's report if a resident does not have a bowel movement in a while and can additionally look in the dashboard. LPN-B stated if a resident had no bowel movement in three days, they provided prune juice and further stated R4 complained of constipation a while ago. LPN-B stated she expected staff to administer as needed (PRN) medications and complete a bowel assessment and verified R4 did not have PRN medications administered in June and added R4 had senna-docusate sodium, but it	F0684		

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F0684 SS = D	Continued from page 11 was not working and verified R4 was not on any additional medications for constipation. LPN-B viewed the aide documentation and stated they would administer a suppository and if the suppository wasn't effective, would call the physician to see about other interventions. LPN-B further stated R4's risk factors for constipation was R4 was bedbound and immobile and additionally R4 already had a diagnosis of constipation. During interview on 7/24/25 at 10:36 a.m., LPN-F stated she had to administer Miralax to R4. LPN-F viewed R4's orders and verified R4 had no order for Miralax. During interview on 7/24/25 at 11:07 a.m., LPN-F stated she received an order for Miralax for R4 and added R4 had problems with constipation and just received an order. During interview on 7/24/25 at 11:46 a.m., LPN-F stated resident refusals were documented and bowel movements were documented in the Tasks form and stated if a resident had problems with constipation they could administer Miralax and further stated R4 asked for bowel meds for the first time today and stated he did not want a suppository and always refused the bisacodyl. Further, LPN-F stated she would have expected staff follow up sooner if resident refused the bisacodyl so R4 could have something else instead. During interview on 7/24/25 at 12:03 p.m., the director of nursing (DON) stated bowel status was monitored in the clinical dashboard and further stated they utilized standing orders and if a medication was utilized off the standing orders, the medication was transcribed to the MAR. Further, the DON stated if medications were not working expected staff to complete an assessment if a resident went more than 3 days without a bowel movement and stated bowel movements were documented under Tasks in bowel continence and size. Further, if a resident refused bisacodyl, expected staff follow up with a provider and obtain a new protocol. The DON stated it was important for R4 because he had a diagnosis of constipation and did not get out of bed. On 7/24/25 at 12:18 p.m., a new order for Miralax 17 grams every day in the a.m., was entered in the physician's orders form. A policy was requested, but the facility did not have a policy.			F0684			
F0699 SS = D	Trauma Informed Care			F0699	The alleged deficiencies for resident R8 have been corrected as of July 23, 2025. The Social Services		10/01/2025

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F0699 SS = D	Continued from page 12 CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to assess trauma history and identify potential triggers for 1 of 1 residents (R8) with post-traumatic stress disorder (PTSD). Findings include: R8's quarterly Minimum Data Set dated 4/22/25, indicated R8 was cognitively intact and had diagnoses of anxiety, depression and PTSD. R8's trauma screening assessment dated 11/1/24, indicated R8 had experienced a traumatic event, and a referral was made for a counselor or therapist. The assessment lacked information of the traumatic event and lacked assessment of anything that may trigger R8's trauma experience. R8's care plan dated 11/7/24, indicated R8 had experienced trauma/PTSD and referred staff to Associated Clinic of Psychology (ACP)notes. R8's care plan lacked identification of triggers for R8's PTSD. Interventions included therapy referral if indicated, chaplain visits as requested, consistent staffing if able, validate feelings and approach calmly. R8's ACP progress note dated 3/25/25, indicated R8 received ACP services for persistent depressive disorder and PTSD. ACP indicated continued services were required to maintain and improve R8's functioning as emotional symptoms had affected R8's functioning. When interviewed on 7/21/25 at 12:23 p.m., R8 stated staff often did not knock when entering the room, "even into the bathroom when I am naked"! R8 further stated she did not like when people surprised her or came up behind her. "I have PTSD and just don't like surprises". R8 was not sure if staff ever talked with her about PTSD or if staff were even aware of it. When interviewed on 7/23/25 at 9:28 a.m., nursing	F0699	Continued from page 12 Director completed a comprehensive trauma history assessment for R8, identified potential triggers, and updated the care plan accordingly. Social Services staff were immediately educated on trauma informed care planning and assessment. The Social Services Director was responsible for implementing these corrections. Residents who have a diagnosis of PTSD or other trauma history have the potential to be affected by the alleged deficient practice. The Social Services Director has completed audits of all current residents' records with a diagnosis of PTSD or trauma history as of August 29, 2025 to ensure no other residents were affected. Education will be provided for all IDT members on trauma-informed care processes on 9/3/25. Trauma has been added to the Point Click Care Kardex categories and all applicable interventions will be pushed to the nursing assistant care guide. The Social Services Director or designee will audit all new admissions and quarterly reviews for residents with PTSD or trauma-related diagnoses, of 1 month until 4 weeks of 100% compliance. Audit results will be presented to the QAPI committee, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. Facility will be in compliance as of 10/1/2025.	

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F0699 SS = D	Continued from page 13 assistant (NA)-B stated R8 required assist of one for transferring and toileting. NA-B stated R8 was not sure if R9 had PTSD and wasn't aware of any triggers that would upset R8. NA-B reviewed their tablet and verified there was nothing about PTSD on their task sheet. The only thing was on there was to monitor for depression. When interviewed on 7/23/25 at 9:50 a.m., registered nurse (RN)-D was not sure if R8 had PTSD. RN-D stated R8 had some behavior monitoring in place for depression and side effects of her medications. RN-D was not aware of any possible triggers or behaviors for R8. RN-D verified R8's care plan mentioned the diagnosis of PTSD, however did inform staff of any triggers for R8 and further stated that was where that information should be, When interviewed on 7/23/25 at 12:12 p.m., the Director of Social Services (DSS) stated a trauma assessment was completed upon admission and as needed during the resident stay. DSS stated the assessment should identify PTDS and assess for triggers and what kind of support was helpful. This information then put in the care plan. DSS had recently started this job and has just become aware of R8's PTSD and was not aware of any triggers as it had not been discussed. DSS would expect R8's assessment to include any triggers for R8's PTSD as well as the care plan. A facility policy titled Trauma Informed Care dated 2025, directed staff to identify a residents history of trauma including potential triggers or stressors that may prompt recall of a traumatic event. The identified triggers will have trigger-specific interventions in place to decrease effects of the trigger and ensure the information was included in the plan of care.	F0699		
F0745 SS = D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is NOT MET as evidenced by: Number of residents sampled:2Number of residents cited:2 Findings include: R11's quarterly Minimum Data Set (MDS) dated 6/3/25,	F0745	All residents affected by R105s outburst were interviewed by the Director of Social Services and all affected residents were offered additional support and/or declined additional support. R105 had a new trauma-based assessment done with care plan review and changes on 7/24/25. All residents were audited for mood/behavior notes or events that require social service follow up for the last 60 days. Social service completed visits with identified residents and corrected any social service needs. The Social Services Director and staff were reeducated on the essential job functions related to follow up of mood and behavior with residents.	10/01/2025

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NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD , WOODBURY, Minnesota, 55125	
(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) COMPLETION DATE
F0745 SS = D	Continued from page 14 indicated R11 was cognitively intact and had diagnoses of anxiety and depression. R11's care plan revised 12/15/24, indicated R11 had a psychosocial well-being problem related to depression and anxiety. Interventions included to encourage R11 to verbalize feelings, perceptions and fears and help identify precipitating factors of stressors. R11's medical record lacked indication follow up was completed after a behavioral outburst by R105. R105's admission MDS dated 5/24/25, indicated R105 was cognitively intact and had diagnoses of adjustment disorder with mixed disturbances and conduct and heart failure. R105's nursing progress note dated 6/17/25 at 8:48 p.m., indicated R105 had loud and disruptive behaviors for over 4 hours. The note indicated other residents were visibly upset from the behavior. A message was left for the nurse manager. R105's nursing progress note dated 7/19/25 at 9:51 p.m., indicated R105 was yelling and cursing at staff. R105 was disrupting other residents rest time. R105's nursing progress note dated 7/20/25 at 9:09 p.m., indicated after R105 was assisted into the wheelchair the resident became disruptive and was yelling and cursing at staff. R105 was so disruptive, other residents started to complain. The nurse in charge was notified and advised to call 911 due to "uncontrollable behavior". Police and ambulance staff arrived with resident refusing to go to hospital. After, R105 calmed down and staff assisted back to bed. R105's care plan revised 5/8/25, indicated R105 exhibited angry outbursts, yelling and throws items. Interventions included a behavioral health consult. Triggers include needs not being met upon request, especially when brief wet. Furthermore, R105 had potential for communication problem with difficulty understanding verbal content related to mood and anxiety. Interventions included provide a safe environment, anticipate needs, assist with incontinent cares timely, and to observe effectiveness of communication strategies. When interviewed on 7/21/25 at 4:56 p.m., R11 stated R105 was always yelling and screaming. R11 stated "yesterday I was afraid of her". R105 was swearing and yelling so much, it was scary, and I was afraid of what	F0745	Continued from page 14 The Regional Social Work Consultant will audit mood and behavior progress notes for Social Work follow up two times weekly for four weeks. Audits will be reviewed at the monthly QAPI meeting to discuss trends, patterns and continued recommendations for process and monitoring and continued compliance. Facility will be in compliance as of 10/1/2025.	

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F0745 SS = D	Continued from page 15 was going to happen. Suddenly, the police were here. R11 didn't know what had happened and hoped it didn't happen again. When interviewed on 7/23/25 at 12:35 p.m., nursing assistant (NA)-B stated R105 yelled out when she wanted help. NA-B stated she had heard about the police being notified however was not aware of why. NA further stated some of the residents down the hall had talked about the police being here when R105 was upset, but they didn't go into details. When interviewed on 7/23/25 at 12:39 p.m., registered nurse (RN)-E stated R105 would scream at the top of her lungs and sometimes came out of her room and would scream in the hallway. RN-E stated it "was scary when R105 would do that as she was intimidating". RN-E was aware of 911 was called due to R105's behavior when it was out of control and verified R105's behavior was "very scary" for other residents. RN-E stated residents down the hall had voiced concerns about it. When interviewed on 7/23/25 at 1:45 p.m., RN-F stated any resident incidents were talked about during morning meeting. RN-F attempted to talk to R105, however R105 did not want to talk and wanted to talk later. RN-F had not returned to discuss the situation. RN-F further stated all they really knew about the situation was what was written in the progress note. No follow up had occurred with R105, R11 or other residents. When interviewed on 7/23/25 at 1:57 p.m., the Director of Social Services (DSS) stated they reviewed the 72-hour report on Mondays to review any behavior incidents from the weekend. DSS was aware of R105's from the report and had read about it in the progress notes. DSS had followed up with R8 who voiced concerns during an assessment, however had not followed up with any other residents to determine if there was any support needed after the police incident and was not aware of R11's feelings of the situation. A facility document titled Social Worker- Senior Living dated 6/6/22, indicated the social services department was responsible for providing each residents emotional and psychological needs from admission to discharge.			F0745			
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -			F0812	On July 21, 2025, all expired, unlabeled or improperly stored food was immediately discarded from the main cool, freezer and unit refrigerators. All freezers, cooler and unit refrigerators were audited to ensure all expired, unlabeled or improperly		10/01/2025

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

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F0812 SS = E	Continued from page 16 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food items were disposed of when needed and were properly stored, labeled, and dated. This had potential to affect all residents, staff, and visitors who consumed food from the main kitchen, and dining refrigerators. Findings include: During the initial kitchen tour on 7/21/25 at 12:03 p.m., the large refrigerator in the hallway across the main kitchen had an opened package of tortilla shells which were not secured closed and not labeled with an opened date. CD and kitchen supervisor (KS)-D stated the kitchen served tacos over the weekend. The large freezer in the hallway across from the main kitchen had meat in an unlabeled freezer bag with a zip lock. KS-D stated the bag contained cooked ribs they used the day prior. The freezer contained meat in clear, tight-sealed packaging and did not contain a label. KS-D stated the meat was pork shoulder which was delivered to the kitchen and expected the label to be cut off from the original box and placed on the meat if the box got damaged. During continued tour with the CD, the second-floor refrigerator in the dining room down the left hallway had a cup from Chick-Fil-A with a sticky note which contained a room number and no date. CD stated nursing	F0812	Continued from page 16 stored food was immediately discarded. The policy for Food Storage and Labeling and the Food Disposal policy were reviewed and updated if applicable. The Food Service Director will provide education to all dietary staff, including cooks, dietary aides, and kitchen supervisors on the policies for Food Storage and Food Disposal. Recurrence will be prevented by: Food Service Director of Designee will audit all facility freezers, coolers and unit refrigerators 2 times per week for 4 weeks to assure compliance. Audits will be reviewed at the monthly QAPI meeting to discuss trends, patterns and continued recommendations for process monitoring and continued compliance. The facility will be in compliance as of 10/1/2025.	

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F0812 SS = E	Continued from page 17 may know more about the contents, and they did not let food or items like that stay in the refrigerator longer than a day. CD stated the servers go through the dining refrigerators every shift. During observation and interview on 7/21/25 at 12:49 p.m., KS-D expected items in the refrigerator to be labeled and dated and stated staff checked the refrigerators daily. The third-floor refrigerator in the dining room closest to the elevators contained a fast-food package with a receipt which read 7/7/25. Another type of to-go box was labeled 6/15/25. Another food container was labeled with a resident name, but the date was not seen before KS-D removed the item. The freezer contained at least two freezer meals, such as mashed potatoes and cheddar broccoli freezer meals, from a resident with use by dates of 3/2/24 and February 2024. KS-D removed other items from the freezer and stated they had dates of 2024. During observation and interview on 7/21/25 at 1:22 p.m., the second-floor refrigerator in the dining room closest to the elevators had two packages of fully cooked cheddar smoked sausages. Nursing assistant (NA)-B verified the packages did not have a resident name and a use by date of 7/11/25. During interview on 7/23/25 at 12:35 p.m., dietary aide (DA)-B stated the culinary staff who served on the floor were responsible for checking the refrigerators for unlabeled or outdated items. During observation and interview on 7/23/25 at 12:41 p.m., KS-E stated resident food items were thrown away if expired or past use by date. In the large refrigerator in the hallway across from the main kitchen, there was a pan with meat and liquid which did not have a date or label. KS-E stated the meat was prepped the day prior to marinate and was going to be used for tonight's dinner. Ground beef was in its original packaging and box and had red liquid visible inside the bottom part of the tight-sealed packaging. KS-E stated the ground beef was raw and was going to be used for tomorrow night and Saturday lunch. KS-E stated the ground beef was delivered fresh on 7/17/25 and verified the package had a use by or freeze by date of 7/21/25. During follow-up interview on 7/24/25 at 9:53 a.m., NA-B stated staff were supposed to label and date resident or other food items placed in the dining room refrigerators or freezers. NA-B stated both dietary and nursing staff were responsible to ensure food was labeled and disposed of when needed.		F0812				

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F0812 SS = E	Continued from page 18 During interview on 7/24/25 at 1:17 p.m., cook (CK)-A stated food should be closed and wrapped and labeled with an opened date. CK-A stated how long the kitchen kept food depended on what the item was. During interview on 7/24/25 at 1:37 p.m., the CD expected staff to wrap, cover, label, and date used food at the end of the shift to keep the quality of the item and ensure items were not old or past the date it should be used. CD expected food prepped ahead of time to be dated when it was prepared and then used in a day and a half. CD stated nursing was responsible for resident food items in the refrigerator. CD stated dietary staff did not use the microwaves in the resident dining areas and were going to start taking the responsibility to clean them. During interview on 7/24/25 at 3:36 p.m., the director of nursing (DON) stated staff who placed food in the refrigerator or freezer or who served food should label and date food to ensure they served safe food. Lifespark Senior Living and Senior Care Communities Food Brought in to Residents from Outside for Storage and Consumption policy dated 2/2019, indicated staff checked any food or beverage brought into the facility for resident consumption. Food or beverages brought in were labeled with the resident's name, room number, and dated by nursing with the current date the item(s) was brought to the facility for storage. The policy directed nursing staff to monitor resident's room, unity pantry, and refrigeration units for food and beverage disposal. New Horizon Foods Skilled Nursing Facility Food and Beverage Labeling Policy dated 1/1/25, indicated food items were labeled with what the item was, when it was prepared or opened, and when it should be used or discarded if need be. The policy stated resident-specific items should be labeled "accordingly" and handled with care. The policy directed designated staff to check food storage areas periodically and may discard any item which lacked proper labeling or appeared questionable.		F0812				
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a		F0880	F0880 – Infection Prevention & Control: Transmission-Based Precautions and Infection Surveillance The alleged deficiencies for resident R111 have been corrected as of 07/24/2025. Upon identification, symptoms were assessed and resident was determined to		10/01/2025	

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F0880 SS = E	Continued from page 19 safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff			F0880	Continued from page 19 be asymptomatic. Stool sample testing was discontinued per provider orders. Nursing staff received immediate re-education on TBP and C. difficile infection control procedures. The Director of Nursing (DON) was responsible for implementing these corrections. Residents who have an active order for stool sample collection for C. difficile or other infectious indications have the potential to be affected by the alleged deficient practice. The Infection Preventionist (IP) completed audits of all current residents with orders for stool sample collection and those on transmission-based precautions as of 07/25/2025 to ensure no other residents were affected. The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: All nursing staffing will receive in-service training on transmission-based precautions, infection surveillance/symptom monitoring, and the specific protocol for suspected or confirmed C. difficile cases by 09/12/2025. The Infection Surveillance and Transmission-Based Precautions policies were reviewed as of 07/25/2025 to clarify procedures for initiating TBP when C. difficile is suspected and protocol for symptom monitoring. Procedure revised to implement every shift documentation of symptoms with those on transmission-based precautions. The facility will monitor performance to ensure sustained compliance. The Infection Preventionist or designee will audit all new orders for stool sample collection, the implementation of TBP, and documentation in electronic medical record for symptom monitoring three times weekly for a minimum of 4 consecutive weeks of 100% compliance. Audit results will be presented to the QAPI committee, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. The facility will be in substantial compliance by 10/01/2025.		

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F0880 SS = E	Continued from page 20 involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement transmission-based precautions (TBP) and infection surveillance for 1 of 1 resident (R111) who had an active order to collect a stool sample for Clostridioides difficile (C. diff). Findings include: Review of R111's medical record included diagnosis list dated 7/24/25 which included End stage renal disease, diarrhea unspecified, and gastritis. Review of R111's Medication Administration Record (MAR) dated July 2025 indicated a physician order "Collect Stool and send to the lab for C-Diff every loose stool D/C (discontinue) once the stool collected." The order was dated 7/21/25, and every shift through 7/24/25 had charted "NO BM." R111's Medication Administration Record for July 2025, directed staff to collect a stool sample and send to the lab for C. diff every shift for loose stool and to discontinue the order once R111's progress notes did not indicate if R111 was placed on precautions or any additional details on when symptoms started and what prompted testing for C. diff. the stool was collected with start date of 7/21/25. R111's progress notes dated 7/22/25 to 7/24/25, indicated R111 did not have a bowel movement to collect for a sample, or R111's bowel movement was not		F0880				

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F0880 SS = E	Continued from page 21 collected due to R111 resting upon return from dialysis.The facility's infection surveillance line list dated July 2025 did not include R111. Observation on 7/21/25 at 2:00 p.m., R111 room door was noted to have an Enhanced Barrier Precautions (EBP) sign. The sign indicated "everyone must: clean their hands, including before and when leaving the room." "Providers and staff must also: wear gloves and gown for the following high-contact resident care activities. Dressing, Bathing/Showering, Transferring, Changing Linen, providing hygiene, changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy tube, Wound care: any skin opening requiring a dressing." Interview on 7/21/25 at 2:15 p.m., R111's family indicated R111 had a loose stool in the morning, so the facility started the precautions again. R111's family indicated R111 was tested for C-diff (clostridium difficile) (inflammation of the colon caused by the bacteria Clostridium difficile) while in the hospital. Interview on 7/24/25 at 2:41 p.m., registered nurse (RN)-G indicated R111 had one loose stool on 7/21/25 when the nurse practitioner (NP) was here, and the NP wrote the order for the stool specimen, and the resident has not had another loose stool since. Interview on 7/24/25 at 3:07 p.m., Licensed Practical nurse (LPN)-G verified R111's orders included an order for a stool sample, but R111 had not had a loose stool. LPN-G indicated if an order for a stool sample for C-diff was received, the resident should be put on contact precautions and Assistant Director of Nursing should be notified. LPN-G indicated the difference between EBP and Contact precautions are that every time someone enters the resident's room, they must wear PPE, no matter the reason. Interview on 7/24/25 at 3:14 p.m., RN-G indicated the Infection Control nurse should have been notified of the order and the resident should have been put on Contact Precautions until the stool specimen was collected and the results came back. RN-G indicated Contact Precautions means that all staff must wear PPE (Personal Protective Equipment) whenever entering the room. During interview on 7/24/25 at 1:56 p.m., the infection preventionist (IP) expected staff to place R111 on contact precautions until a negative lab returned for		F0880				

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F0880 SS = E	Continued from page 22 loose stools. IP stated R111 was not on the line list and did not know about R111's loose stool(s) or order to test for C. diff. IP expected staff to notify them about R111's symptoms and ordered test. During interview on 7/24/25 at 3:36 p.m., the director of nursing (DON) expected staff to place residents with a pending stool sample for C. diff on contact precautions to stop the potential spread of infection. The DON stated pending tests where not typically on the infection surveillance line list. The DON expected staff to document what happened and triggered the test, signs and symptoms, and what was tried. The Woodbury Health Care Center's Infection Surveillance policy dated December 2020, indicated a written line list of infections to assist in organizing information about resident infections should be monitored and updated regularly to identify clusters, outbreaks, and other unusual infection patterns. The policy indicated cues for triggering a possible infection included antibiotic starts and resident signs and symptoms. The policy directed the IP to review infection surveillance definitions to determine if infection criteria were met if symptoms on the line list suggested a potential infection. Lifespark Senior Living and Senior Care Communities Infection Prevention and Control Program dated 4/2020, directed the IP to implement and monitor guidelines and procedures for isolation precautions. A specific policy on transmission based precautions was not provided.	F0880		

Minnesota State Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/21/25 - 7/24/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.			20000			10/01/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2025	
NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD , WOODBURY, Minnesota, 55125			
(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) COMPLETION DATE	
20000	Continued from page 1 The following complaints were reviewed during the survey: H52359827C (MN00114238) H52357308C (MN00113866) H52359844C (MN00111361) H52359828C (MN00110944) H52359829C (MN00109552) H52359830C (MN00105523) H52351060C .(2568505) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul		20000				

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20000	Continued from page 2 .htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.		20000				
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide routine care conferences to allow for resident/ family participation and interdisciplinary review, and update, if necessary, of the care plan for 1 of 1 resident (R50) reviewed for care conferences. Findings include: R 50's quarterly Minimum Data Set (MDS) dated 6/16/25 severely cognitively impaired, unable to communicate clearly, and understand others. R50 had the following diagnoses: major depressive disorder, Alzheimer's, unspecified psychosis not due to a substance or known physiological condition, unspecified dementia, psychotic disturbance, mood disturbance, and anxiety. R50's electronic medical record (EMR) indicated R50 had a care conference on 6/24/25, EMR indicated the last documented care conference for R50 was 10/7/24. During an interview on 7/21/25 at 6:28 p.m., R50's family member (FM)-A stated the facility were doing care conferences quarterly then it changed. FM-A stated		20570	Corrected		10/01/2025	

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20570	Continued from page 3 it was explained to them the social worker left the facility, so no care conferences were offered. FM-A wanted to be included in care conferences and give input for care plan of R50. During an interview on 7/24/25 at 11:48 a.m., LPN manager (LPN)-A stated the care conferences and care plan review were held quarterly, annually, if changes occur, staff or family request. The expectation was informing resident, family, dietary, physical, occupational and speech therapy, speech, social services, community life, nurses, doctors, director of nurses and executive director to attend care conference. During an interview on 7/24/25 at 12:16 p.m., the director of social services (SS)-A stated the expectations for care conferences and care plan review were held quarterly, annually, and if requested. The care conference and care plan were correlated with the MDS. The expectation was informing resident, family, dietary, physical, occupational and speech therapy, , social services, community life, nurses, doctors, director of nurses and executive director to attend care conference. The importance of care conferences was to collaborate across disciplines, provide comprehensive assessments, meet the psychosocial needs of residents and families and provide resources. During an interview on 7/24/25 at 3:14 p.m., the director of nurses (DON)-A stated the process for care conferences were to be done upon admit, quarterly and annually. The care plans and care conferences are assessed in the same time frame. The expectations for care conferences were to collaborate with family and resident and address any concerns. The family, resident and members of the interdisciplinary team (IDT) were informed of the time and date of care conference. The importance and individualized care plans are through care conferences, the collaboration with family and resident learn about them, how they grow and meet their needs at their level. A facility policy titled Care Conferences stated the care conference guidelines indicated the IDT would review and update after: · *Initial: Complete Care Conference after admission MDS, CAAs, care plan was completed · Quarterly · Discharge Planning			20570			

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20570	Continued from page 4 · Change in condition As needed for any resident and/or family request SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance with revision of care plans and care conferences. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	20570		
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to ensure symptoms of constipation were acted upon and assessed to determine what, if any interventions were needed to promote appropriate bowel management for 1 of 1 resident (R4). Findings include: R4's Optional State Assessment (OSA) dated 7/8/25, indicated R4 did not reject care, required extensive assistance with bed mobility and toilet use, and was not on a urinary or bowel toileting program. R4's Medical Diagnosis form indicated the following diagnoses: hemiplegia (paralysis of one side of the body) affecting the left nondominant side, diabetes mellitus (DM), muscle weakness, chronic idiopathic (without a known cause) constipation. R4's care plan dated 10/3/24 indicated R4 had a self care deficit due to a stroke and required substantial to maximal assist of one for personal hygiene. R4's care plan dated 7/17/25 indicated R4 refused to get out of bed due to refusing the mechanical lift. R4's care plan dated 10/14/24, indicated R4 had	20875	Corrected	10/01/2025

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20875	Continued from page 5 frequent incontinence of bowel and bladder and interventions indicated to record bowel movements daily and used a bed pan and urinal. R4's care plan dated 7/8/25, indicated R4 had a nutrition problem due to diagnoses that included constipation. R4's physician's orders form indicated the following orders: 4/24/25, senna-docusate sodium (stool softener) oral tablet 8.6-50 milligram (MG) tablet, give one tablet twice a day.4/24/25, bisacodyl rectal suppository (a laxative) 10 mg, insert 10 mg rectally every 72 hours as needed for constipation.R4's medication administration record (MAR) and treatment administration record (TAR) dated June 2025, indicated R4 received senna-docusate sodium twice daily. Further, R4 did not utilize any PRN bisacodyl medication. R4's MAR and TAR dated July 2025, and saved 7/24/25 at 7:08 a.m., indicated R4 received senna-docusate sodium twice daily. Further, R4 did not utilize any PRN bisacodyl medication. R4's Task form titled, Bowel Continence & BM, dated 5/26/25, to 7/24/25, indicated the following:On 6/13/25 at 2:22 p.m., R4 had a large bowel movement. No further bowel movements were documented until 6/18/25 at 7:42 p.m., when R4 had a large bowel movement. On 6/18/25 at 7:42 p.m., R4 had a large bowel movement. No further bowel movements were documented until 6/22/25 at 9:49 p.m., when R4 had a medium bowel movement.On 6/23/25 at 7:40 p.m., R4 had a large bowel movement. No further bowel movements were documented until 6/27/25 at 5:55 a.m., when R4 had a medium bowel movement. On 7/1/25 at 8:16 p.m., R4 had a large bowel movement. No further bowel movements were documented until 7/6/25 at 2:41 p.m., when R4 had a large bowel movement. On 7/8/25 at 12:34 p.m., R4 had a large bowel movement. No further bowel movements were documented until 7/14/25 at 2:29 p.m., when R4 had a large bowel movement.On 7/17/25 at 9:26 p.m., R4 had a medium bowel movement. No further bowel movements were documented until 7/21/25 at 9:45 p.m., when R4 had a small bowel movement. R4's nursing progress notes were reviewed from 5/26/25, to 7/23/25, and lacked information R4 was administered as needed bisacodyl if R4 had no bowel movement for 72 hours. Further, progress notes lacked physician notification during days R4 went longer than 72 hours		20875				

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20875	Continued from page 6 without a bowel movement. Progress notes lacked information R4 was going longer than 72 hours without having a bowel movement. R4's Comprehensive Nursing Data Collection form dated 7/2/25, indicated R4 was alert and oriented to person, place, time, and situation, had frequent bladder incontinence, and was continent of bowels. Further, R4's bowel sounds were present and active, had a soft and rounded abdomen, and under a heading, "Date of last BM" indicated, "see CNA task". During interview and observation on 7/21/25 between 12:44 p.m., and 12:51 p.m., R4 was in his bed and stated he hadn't gone to the bathroom in 5 days and stated he felt some movement, but the stool did not want to come and added this was an everyday concern. R4 stated staff provided a bedpan and stated he asked about Miralax (a medication to treat constipation) which he stated sometimes helped and prune juice and added it was very uncomfortable. R4 stated his normal pattern was every other day not every 5 days. During interview on 7/24/25 at 9:44 a.m., licensed practical nurse (LPN)-B stated refusals were documented in a progress note and staff documented bowel movements in the Tasks form where the nursing assistants (NA) document the size of the bowel movement and the NA's report if a resident does not have a bowel movement in a while and can additionally look in the dashboard. LPN-B stated if a resident had no bowel movement in three days, they provided prune juice and further stated R4 complained of constipation a while ago. LPN-B stated she expected staff to administer as needed (PRN) medications and complete a bowel assessment and verified R4 did not have PRN medications administered in June and added R4 had senna-docusate sodium, but it was not working and verified R4 was not on any additional medications for constipation. LPN-B viewed the aide documentation and stated they would administer a suppository and if the suppository wasn't effective, would call the physician to see about other interventions. LPN-B further stated R4's risk factors for constipation was R4 was bedbound and immobile and additionally R4 already had a diagnosis of constipation. During interview on 7/24/25 at 10:36 a.m., LPN-F stated she had to administer Miralax to R4. LPN-F viewed R4's orders and verified R4 had no order for Miralax. During interview on 7/24/25 at 11:07 a.m., LPN-F stated she received an order for Miralax for R4 and added R4 had problems with constipation and just received an	20875		

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20875	Continued from page 7 order. During interview on 7/24/25 at 11:46 a.m., LPN-F stated resident refusals were documented and bowel movements were documented in the Tasks form and stated if a resident had problems with constipation they could administer Miralax and further stated R4 asked for bowel meds for the first time today and stated he did not want a suppository and always refused the bisacodyl. Further, LPN-F stated she would have expected staff follow up sooner if resident refused the bisacodyl so R4 could have something else instead. During interview on 7/24/25 at 12:03 p.m., the director of nursing (DON) stated bowel status was monitored in the clinical dashboard and further stated they utilized standing orders and if a medication was utilized off the standing orders, the medication was transcribed to the MAR. Further, the DON stated if medications were not working expected staff to complete an assessment if a resident went more than 3 days without a bowel movement and stated bowel movements were documented under Tasks in bowel continence and size. Further, if a resident refused bisacodyl, expected staff follow up with a provider and obtain a new protocol. The DON stated it was important for R4 because he had a diagnosis of constipation and did not get out of bed. On 7/24/25 at 12:18 p.m., a new order for Miralax 17 grams every day in the a.m., was entered in the physician's orders form. A policy was requested, but the facility did not have a policy. SUGGESTED METHOD OF CORRECTION:The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance with bowel protocols regarding constipation. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days		20875				
21015	Dietary Staff Requirements- Sanitary conditi CFR(s): MN Rule 4658.0610 Subp. 7 Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review,		21015	Corrected		10/01/2025	

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21015	Continued from page 8 the facility failed to ensure food items were disposed of when needed and were properly stored, labeled, and dated. This had potential to affect all residents, staff, and visitors who consumed food from the main kitchen,and dining refrigerators. Findings include: During the initial kitchen tour on 7/21/25 at 12:03 p.m., the large refrigerator in the hallway across the main kitchen had an opened package of tortilla shells which were not secured closed and not labeled with an opened date. CD and kitchen supervisor (KS)-D stated the kitchen served tacos over the weekend. The large freezer in the hallway across from the main kitchen had meat in an unlabeled freezer bag with a zip lock. KS-D stated the bag contained cooked ribs they used the day prior. The freezer contained meat in clear, tight-sealed packaging and did not contain a label. KS-D stated the meat was pork shoulder which was delivered to the kitchen and expected the label to be cut off from the original box and placed on the meat if the box got damaged. During continued tour with the CD, the second-floor refrigerator in the dining room down the left hallway had a cup from Chick-Fil-A with a sticky note which contained a room number and no date. CD stated nursing may know more about the contents, and they did not let food or items like that stay in the refrigerator longer than a day. CD stated the servers go through the dining refrigerators every shift. During observation and interview on 7/21/25 at 12:49 p.m., KS-D expected items in the refrigerator to be labeled and dated and stated staff checked the refrigerators daily. The third-floor refrigerator in the dining room closest to the elevators contained a fast-food package with a receipt which read 7/7/25. Another type of to-go box was labeled 6/15/25. Another food container was labeled with a resident name, but the date was not seen before KS-D removed the item. The freezer contained at least two freezer meals, such as mashed potatoes and cheddar broccoli freezer meals, from a resident with use by dates of 3/2/24 and February 2024. KS-D removed other items from the freezer and stated they had dates of 2024. During observation and interview on 7/21/25 at 1:22 p.m., the second-floor refrigerator in the dining room closest to the elevators had two packages of fully cooked cheddar smoked sausages. Nursing assistant (NA)-B verified the packages did not have a resident name and a use by date of 7/11/25.			21015			

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21015	Continued from page 9 During interview on 7/23/25 at 12:35 p.m., dietary aide (DA)-B stated the culinary staff who served on the floor were responsible for checking the refrigerators for unlabeled or outdated items. During observation and interview on 7/23/25 at 12:41 p.m., KS-E stated resident food items were thrown away if expired or past use by date. In the large refrigerator in the hallway across from the main kitchen, there was a pan with meat and liquid which did not have a date or label. KS-E stated the meat was prepped the day prior to marinate and was going to be used for tonight's dinner. Ground beef was in its original packaging and box and had red liquid visible inside the bottom part of the tight-sealed packaging. KS-E stated the ground beef was raw and was going to be used for tomorrow night and Saturday lunch. KS-E stated the ground beef was delivered fresh on 7/17/25 and verified the package had a use by or freeze by date of 7/21/25. During follow-up interview on 7/24/25 at 9:53 a.m., NA-B stated staff were supposed to label and date resident or other food items placed in the dining room refrigerators or freezers. NA-B stated both dietary and nursing staff were responsible to ensure food was labeled and disposed of when needed. During interview on 7/24/25 at 1:17 p.m., cook (CK)-A stated food should be closed and wrapped and labeled with an opened date. CK-A stated how long the kitchen kept food depended on what the item was. During interview on 7/24/25 at 1:37 p.m., the CD expected staff to wrap, cover, label, and date used food at the end of the shift to keep the quality of the item and ensure items were not old or past the date it should be used. CD expected food prepped ahead of time to be dated when it was prepared and then used in a day and a half. CD stated nursing was responsible for resident food items in the refrigerator. CD stated dietary staff did not use the microwaves in the resident dining areas and were going to start taking the responsibility to clean them. During interview on 7/24/25 at 3:36 p.m., the director of nursing (DON) stated staff who placed food in the refrigerator or freezer or who served food should label and date food to ensure they served safe food. Lifespark Senior Living and Senior Care Communities Food Brought in to Residents from Outside for Storage and Consumption policy dated 2/2019, indicated staff			21015			

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21015	Continued from page 10 checked any food or beverage brought into the facility for resident consumption. Food or beverages brought in were labeled with the resident's name, room number, and dated by nursing with the current date the item(s) was brought to the facility for storage. The policy directed nursing staff to monitor resident's room, unity pantry, and refrigeration units for food and beverage disposal. New Horizon Foods Skilled Nursing Facility Food and Beverage Labeling Policy dated 1/1/25, indicated food items were labeled with what the item was, when it was prepared or opened, and when it should be used or discarded if need be. The policy stated resident-specific items should be labeled "accordingly" and handled with care. The policy directed designated staff to check food storage areas periodically and may discard any item which lacked proper labeling or appeared questionable. SUGGESTED METHOD OF CORRECTION: The director of nursing, director of dietary services and/or designee could assure policies and procedures are current, implemented, and monitored to assure kitchen staff maintain clean and sanitary food preparation and storage areas. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21015				
21100	Food Supplies; Storage of Perishable food CFR(s): MN Rule 4658.0650 Subp. 5 Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food items were disposed of when needed and were properly stored, labeled, and dated. This had potential to affect all residents, staff, and visitors who consumed food from the main kitchen,and dining refrigerators. Findings include: During the initial kitchen tour on 7/21/25 at 12:03 p.m., the large refrigerator in the hallway across the		21100	Corrected		10/01/2025	

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21100	Continued from page 11 main kitchen had an opened package of tortilla shells which were not secured closed and not labeled with an opened date. CD and kitchen supervisor (KS)-D stated the kitchen served tacos over the weekend. The large freezer in the hallway across from the main kitchen had meat in an unlabeled freezer bag with a zip lock. KS-D stated the bag contained cooked ribs they used the day prior. The freezer contained meat in clear, tight-sealed packaging and did not contain a label. KS-D stated the meat was pork shoulder which was delivered to the kitchen and expected the label to be cut off from the original box and placed on the meat if the box got damaged. During continued tour with the CD, the second-floor refrigerator in the dining room down the left hallway had a cup from Chick-Fil-A with a sticky note which contained a room number and no date. CD stated nursing may know more about the contents, and they did not let food or items like that stay in the refrigerator longer than a day. CD stated the servers go through the dining refrigerators every shift. During observation and interview on 7/21/25 at 12:49 p.m., KS-D expected items in the refrigerator to be labeled and dated and stated staff checked the refrigerators daily. The third-floor refrigerator in the dining room closest to the elevators contained a fast-food package with a receipt which read 7/7/25. Another type of to-go box was labeled 6/15/25. Another food container was labeled with a resident name, but the date was not seen before KS-D removed the item. The freezer contained at least two freezer meals, such as mashed potatoes and cheddar broccoli freezer meals, from a resident with use by dates of 3/2/24 and February 2024. KS-D removed other items from the freezer and stated they had dates of 2024. During observation and interview on 7/21/25 at 1:22 p.m., the second-floor refrigerator in the dining room closest to the elevators had two packages of fully cooked cheddar smoked sausages. Nursing assistant (NA)-B verified the packages did not have a resident name and a use by date of 7/11/25. During interview on 7/23/25 at 12:35 p.m., dietary aide (DA)-B stated the culinary staff who served on the floor were responsible for checking the refrigerators for unlabeled or outdated items. During observation and interview on 7/23/25 at 12:41 p.m., KS-E stated resident food items were thrown away if expired or past use by date. In the large refrigerator in the hallway across from the main		21100				

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21100	Continued from page 12 kitchen, there was a pan with meat and liquid which did not have a date or label. KS-E stated the meat was prepped the day prior to marinate and was going to be used for tonight's dinner. Ground beef was in its original packaging and box and had red liquid visible inside the bottom part of the tight-sealed packaging. KS-E stated the ground beef was raw and was going to be used for tomorrow night and Saturday lunch. KS-E stated the ground beef was delivered fresh on 7/17/25 and verified the package had a use by or freeze by date of 7/21/25. During follow-up interview on 7/24/25 at 9:53 a.m., NA-B stated staff were supposed to label and date resident or other food items placed in the dining room refrigerators or freezers. NA-B stated both dietary and nursing staff were responsible to ensure food was labeled and disposed of when needed. During interview on 7/24/25 at 1:17 p.m., cook (CK)-A stated food should be closed and wrapped and labeled with an opened date. CK-A stated how long the kitchen kept food depended on what the item was. During interview on 7/24/25 at 1:37 p.m., the CD expected staff to wrap, cover, label, and date used food at the end of the shift to keep the quality of the item and ensure items were not old or past the date it should be used. CD expected food prepped ahead of time to be dated when it was prepared and then used in a day and a half. CD stated nursing was responsible for resident food items in the refrigerator. CD stated dietary staff did not use the microwaves in the resident dining areas and were going to start taking the responsibility to clean them. During interview on 7/24/25 at 3:36 p.m., the director of nursing (DON) stated staff who placed food in the refrigerator or freezer or who served food should label and date food to ensure they served safe food. Lifespark Senior Living and Senior Care Communities Food Brought in to Residents from Outside for Storage and Consumption policy dated 2/2019, indicated staff checked any food or beverage brought into the facility for resident consumption. Food or beverages brought in were labeled with the resident's name, room number, and dated by nursing with the current date the item(s) was brought to the facility for storage. The policy directed nursing staff to monitor resident's room, unity pantry, and refrigeration units for food and beverage disposal. New Horizon Foods Skilled Nursing Facility Food and			21100			

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21100	Continued from page 13 Beverage Labeling Policy dated 1/1/25, indicated food items were labeled with what the item was, when it was prepared or opened, and when it should be used or discarded if need be. The policy stated resident-specific items should be labeled “accordingly” and handled with care. The policy directed designated staff to check food storage areas periodically and may discard any item which lacked proper labeling or appeared questionable. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21100				
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement transmission-based precautions (TBP) and infection surveillance for 1 of 1 resident (R111) who had an active order to collect a stool sample for Clostridioides difficile (C. diff). Findings include: Review of R111's medical record included diagnosis list dated 7/24/25 which included End stage renal disease, diarrhea unspecified, and gastritis. Review of R111's Medication Administration Record (MAR) dated July 2025 indicated a physician order "Collect Stool and send to the lab for C-Diff every loose stool		21375	Corrected		10/01/2025	

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21375	Continued from page 14 D/C (discontinue) once the stool collected." The order was dated 7/21/25, and every shift through 7/24/25 had charted "NO BM." R111's Medication Administration Record for July 2025, directed staff to collect a stool sample and send to the lab for C. diff every shift for loose stool and to discontinue the order once R111's progress notes did not indicate if R111 was placed on precautions or any additional details on when symptoms started and what prompted testing for C. diff. the stool was collected with start date of 7/21/25. R111's progress notes dated 7/22/25 to 7/24/25, indicated R111 did not have a bowel movement to collect for a sample, or R111's bowel movement was not collected due to R111 resting upon return from dialysis.The facility's infection surveillance line list dated July 2025 did not include R111. Observation on 7/21/25 at 2:00 p.m., R111 room door was noted to have an Enhanced Barrier Precautions (EBP) sign. The sign indicated "everyone must: clean their hands, including before and when leaving the room." "Providers and staff must also: wear gloves and gown for the following high-contact resident care activities. Dressing, Bathing/Showering, Transferring, Changing Linen, providing hygiene, changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy tube, Wound care: any skin opening requiring a dressing." Interview on 7/21/25 at 2:15 p.m., R111's family indicated R111 had a loose stool in the morning, so the facility started the precautions again. R111's family indicated R111 was tested for C-diff (clostridium difficile) (inflammation of the colon caused by the bacteria Clostridium difficile) while in the hospital. Interview on 7/24/25 at 2:41 p.m., registered nurse (RN)-G indicated R111 had one loose stool on 7/21/25 when the nurse practitioner (NP) was here, and the NP wrote the order for the stool specimen, and the resident has not had another loose stool since. Interview on 7/24/25 at 3:07 p.m., Licensed Practical nurse (LPN)-G verified R111's orders included an order for a stool sample, but R111 had not had a loose stool. LPN-G indicated if an order for a stool sample for C-diff was received, the resident should be put on contact precautions and Assistant Director of Nursing		21375				

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21375	Continued from page 15 should be notified. LPN-G indicated the difference between EBP and Contact precautions are that every time someone enters the resident's room, they must wear PPE, no matter the reason. Interview on 7/24/25 at 3:14 p.m., RN-G indicated the Infection Control nurse should have been notified of the order and the resident should have been put on Contact Precautions until the stool specimen was collected and the results came back. RN-G indicated Contact Precautions means that all staff must wear PPE (Personal Protective Equipment) whenever entering the room. During interview on 7/24/25 at 1:56 p.m., the infection preventionist (IP) expected staff to place R111 on contact precautions until a negative lab returned for loose stools. IP stated R111 was not on the line list and did not know about R111's loose stool(s) or order to test for C. diff. IP expected staff to notify them about R111's symptoms and ordered test. During interview on 7/24/25 at 3:36 p.m., the director of nursing (DON) expected staff to place residents with a pending stool sample for C. diff on contact precautions to stop the potential spread of infection. The DON stated pending tests were not typically on the infection surveillance line list. The DON expected staff to document what happened and triggered the test, signs and symptoms, and what was tried. The Woodbury Health Care Center's Infection Surveillance policy dated December 2020, indicated a written line list of infections to assist in organizing information about resident infections should be monitored and updated regularly to identify clusters, outbreaks, and other unusual infection patterns. The policy indicated cues for triggering a possible infection included antibiotic starts and resident signs and symptoms. The policy directed the IP to review infection surveillance definitions to determine if infection criteria were met if symptoms on the line list suggested a potential infection. Lifespark Senior Living and Senior Care Communities Infection Prevention and Control Program dated 4/2020, directed the IP to implement and monitor guidelines and procedures for isolation precautions. A specific policy on transmission based precautions was not provided.			21375			

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21375	Continued from page 16 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policy and procedures regarding Infection Surveillance and implementation of transmission-based precautions for the resident and provide staff education regarding the policies. The Director of Nursing (DON), ICP, or designee could educate staff on when tracking possible infections and implementing transmission-based precautions is appropriate and initiated. They could also do environmental rounds and chart audits, and re-education anytime EBP or TBP are placed to ensure adequate surveillance is in place. The DON, ICP or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21375				
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure required tuberculosis (TB) testing was completed for 1 of 5 staff members with the potential to affect all 101 residents residing in the facility. Findings include: The Centers for Disease Control (CDC) Guidelines for		21426	Corrected		10/01/2025	

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21426	Continued from page 17 Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, directed all health care workers to receive a two-step tuberculin skin test (TST) or a laboratory blood test for TB upon hire. A facility staff list indicated dietary aide (DA)-A was hired 5/15/25. DA-A's Baseline TB Screening Tool for Health Care Workers dated 4/14/25, indicated DA-A had a first step tuberculin skin test (TST) on 4/14/25 and read negative on 4/16/25. No record of a second step TST was received. During interview on 7/24/25 at 1:56 p.m., the infection preventionist (IP) expected all staff to receive testing for TB before orientation. During interview on 7/24/25 at 3:36 p.m., the director of nursing (DON) reviewed DA-A's Baseline TB Screening Tool for Health Care Workers and TB testing and verified the form did not list a second step TST. The DON stated the facility was a community and did not want to place people at risk for TB. The facility's TB Infection Control Plan dated 6/2023, indicated all health care workers, which included dietary and food service, received a baseline TB screening upon hire with a two-step TST or single blood test to test for infection with Mycobacterium tuberculosis. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review tuberculosis policies and procedures to ensure compliance. The director of nursing (DON) or designee could review the assessment process for staff to be sure the documentation of the TB tests is completed per guidelines. The DON or designee could audit for screening and TB testing for staff. The results of these audits could be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21426				
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the		21565	Corrected		10/01/2025	

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21565	Continued from page 18 attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self administration of medications (SAM) was completed to allow residents to safely administer their own medications for 1 of 1 resident (R68) observed with a medication at the bedside. Findings include: R68's Medical Diagnosis form indicated the following diagnoses: acute and chronic respiratory failure with hypoxia, severe persistent asthma, chronic obstructive pulmonary disease with acute exacerbation, and emphysema. R68's quarterly Minimum Data Set (MDS) dated 6/26/25, indicated intact cognition, and had shortness of breath with exertion when sitting at rest, and when lying flat. R68's care plan dated 4/3/25 indicated R68 could not self-administer medications and nebulizers, and the facility was to administer medications as resident was not safe to independently administer medications at this time. Additionally, a SAM was to be completed quarterly and as needed. R68's physician orders form indicated the following orders:3/23/25, and discontinued on 7/22/25, Albuterol Sulfate HFA inhalation aerosol solution 108 (90 Base) microgram (MCG)/ACT inhaler inhale 1 puff orally every 4 hours as needed for wheezing. Inhale 1-2 puffs into the lungs to be administered by the clinician.7/22/25, Albuterol Sulfate HFA inhalation aerosol solution 108 (90 base) mcg/ACT 2 puffs inhale orally every 4 hours as needed for wheezing to be administered by the clinician. R68's medication administration record (MAR) and treatment administration record (TAR) dated July 2025, lacked information R68 utilized as needed Albuterol. R68's MAR and TAR lacked information R68 could SAM her Albuterol metered dose inhaler (MDI). R68's Self Administration of Nebulizers Evaluation form dated 4/3/25, indicated R68 had a physician's order to self-administer nebulizers and could be left along during administration of nebulizer treatment. The form lacked information whether R68 could self-administer her Albuterol MDI. R68's nursing progress notes were reviewed and lacked		21565				

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21565	Continued from page 19 information R68 could SAM her Albuterol MDI. During observation on 7/21/25 at 1:25 p.m., R68 had an Albuterol inhaler on the bedside table in her room and stated she used the inhaler. During observation on 7/23/25 at 7:14 a.m., R68 had an inhaler on her bedside table. During observation on 7/23/25 at 8:22 a.m., an unknown staff person entered R68's room and delivered her meal and left the room. During observation on 7/23/25 at 8:25 a.m., nursing assistant (NA)-A entered R68's room and placed a packet of butter on the bedside table and left to get R68 a spoon. R68 had the albuterol inhaler with an open date of 12/27 written on the label. At 8:26 a.m., NA-A entered the room to assist R68 with her bed and left the room. During interview and observation on 7/23/25 at 9:10 a.m., licensed practical nurse (LPN)-A entered R68's room and moved R68's meal tray off the bedside table and started R68's nebulizer. At 9:11 a.m., LPN-A left the room with the meal tray. LPN-A stated a few residents can have medications at the bedside and stated those residents had an order to do so and they also have an assessment to make sure they are alert and oriented and further stated for inhalers to be self-administered, staff had to make sure residents understood to how to breathe into the inhaler and take two puffs and stated the technique differed from a nebulizer. LPN-A viewed R68's orders for her Albuterol inhaler and verified the medication was supposed to be administered by the clinician and verified R68's Albuterol inhaler was located on her bedside table and stated that was something that could be followed up on and stated there needed to be an order and stated he looked to the MAR to know if a resident could SAM. During interview on 7/23/25 at 9:24 a.m., LPN-B viewed R68's orders in the paper chart and stated R68 had an order to SAM nebulizers but did not have an order to SAM the Albuterol MDI. During interview on 7/23/25 at 9:28 a.m. with registered nurse (RN)-B and LPN-B, RN-B viewed R68's paper chart and both RN-B and LPN-B stated R68 should have a SAM assessment for the Albuterol MDI in addition to her assessment for nebulizers. LPN-B stated if a resident had a nebulizer the nurse had to assess if the resident could keep the mask on and if a resident had an MDI the nurse had to educate the resident on how	21565		

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21565	Continued from page 20 many puffs they can take and watch them and document if they are able to know the frequency and both RN-B and LPN-B verified R68 did not have a SAM assessment for an MDI, and did not have an order to SAM the Albuterol MDI.During interview on 7/23/25 at 10:41 a.m., the director of nursing (DON) stated if a resident wanted to self-administer their medications, a SAM assessment would be completed, and an order would be obtained from the provider and further stated she expected MDIs would not be kept at the bedside unless it was determined the resident was safe to SAM. A policy, Medication Self Administration Safety Screen and/or Self Administration dated 9/2023, indicated the Medication Self Administration Safety Screen and/or the Self Administration of Nebulizer's Evaluation is only completed if the resident requests to do their own medications or some of their own medications such as inhalers, eye drops or actual pills. Evaluation and approval for self-administration of medications will be based on the Medication Self-Administration Safety Screen and or the Self-Administration of Nebulizer's Evaluation. The IDT will review the summary on the Medication Self-Administration Safety Screen to determine appropriateness of self-administration of medications. The determination will include whether the resident can self-administer medications unsupervised, with supervision or is not safe to administer medications. A physician order will be obtained indicating which medications the resident may self-administer and with or without supervision.SUGGESTED METHOD OF CORRECTION:The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance with self-administration of medications. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days		21565				

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/23/2025. At the time of this survey, Woodbury Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR			K0000			10/01/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/23/2025	
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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. WOODBURY HEALTH CARE CENTER is a 3-story building with a lower level. The building was constructed at 2 different times. The original 2 story building with the lower level was constructed in 1979 and was determined to be of Type II (222) construction. In 1986, the third-floor addition was constructed and determined to be of Type II (222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 155 beds and had a census of 96 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:			K0000			
K0162 SS = D	Roofing Systems Involving Combustibles CFR(s): NFPA 101 Roofing Systems Involving Combustibles			K0162	The alleged deficiencies identified during the life safety survey have been corrected as of July 23, 2025. The damaged section of the ceiling in the east wing corridor was immediately repaired with non-combustible materials in accordance with NFPA 101 requirements. All		10/01/2025

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K0162 SS = D	Continued from page 2 2012 EXISTING Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. Roof covering meets Class C requirements. 2. Roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2 1/2 inches concrete or gypsum fill. 3. Attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain non-combustible ceiling in accordance with the NFPA Life Safety Code 101 2012 edition section 19.1.6.3 subsection 1 and 3. This deficient practice could have an isolated impact on the residents within the facility. Findings include: On 07/23/2025 at pm, it was revealed by observation that the utility storage room was missing ceiling tiles. Ceiling tiles were rmissing due to a water leak. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0162	Continued from page 2 debris was removed, and the area was inspected for compliance. The Maintenance Director was responsible for implementing these corrections. Areas of the building or equipment that could have been similarly affected were assessed. The Maintenance Director conducted a comprehensive audit of all ceiling assemblies in resident rooms, corridors, and common areas as of July 28, 2025 to ensure no other areas were affected by non-compliant ceiling materials or damage. Training will be provided for all maintenance staff regarding the non-combustible materials in accordance with NFPA 101 requirements. This training will be completed by the compliance date below. Ceiling tile observation will be included in maintenance daily rounds. Woodbury Health Care Center will monitor its performance to ensure the corrections noted above are sustained. The Maintenance Director or designee will audit all ceiling assemblies once per week for two months. The Safety Committee will review these audit results and recommend any changes in frequency or scope of audits as needed.		
K0223 SS = F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and			K0223	The alleged deficiencies identified during the life safety survey have been corrected as of July 23, 2025. The Maintenance Director was responsible for implementing the corrections, ensuring all installations met NFPA 101 (2012) requirements. Areas of the building or equipment that could have been similarly affected were assessed. The Maintenance Director conducted a comprehensive audit of all corridor doors throughout the facility as of June 23, 2025 to ensure no other areas were affected. Training will be provided for all maintenance staff regarding the updated policies, safety protocols, and inspection routines. This training will be completed by the compliance date below. Corridor doors are inspected		10/01/2025

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K0223 SS = F	Continued from page 3 * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/23/2025 at 12:04pm, it was revealed by observation that smoke barrier doors on first floor did not close when tested. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0223	Continued from page 3 for compliance monthly. The Maintenance Director or designee will audit all corridor doors for proper self-closing function monthly for a period of at least 3 months. The QAPI/Safety Committee will review these results and recommend any changes in frequency or scope of audits.		
K0321 SS = D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms			K0321	The self-closing devices identified during the life safety survey have been corrected as of September 12, 2025. The Maintenance Director was responsible for implementing these corrections. Areas of the building or equipment that could have been similarly affected were assessed. The Maintenance Director conducted an audit of all hazardous storage rooms in the building as well as all janitorial closets and chemical storage areas, as of July 28, 2025. All other affected doors were corrected as of September 19, 2025. Training will be provided for all maintenance staff regarding the updated policies, safety protocols, and inspection routines noted above. This training will be completed by the compliance date below. Doors will be monitored during the monthly latch and gap inspection. Maintenance will monitor its performance to ensure the corrections noted above are sustained. The Maintenance Director or designee will audit all hazardous storage room doors and related fire safety features monthly for a period of at least 2 months. The QAPI/Safety		10/01/2025

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K0321 SS = D	Continued from page 4 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/23/2025 at 12:11pm, it was revealed by observation that first floor storage room did not have a self-closing device. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0321	Continued from page 4 Committee will review these results and recommend any changes in frequency or scope of audits.		
K0324 SS = D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or			K0324	The wheeled gas-fired stove and griddle had an approved method of attachment and/or alignment mark installed on 09/19/2025 to ensure the appliances were returned to an approve design location after being moved for maintenance and cleaning. 2. The Maintenance Director conducted a comprehensive audit of all commercial cooking areas, including the main kitchen, staff break room kitchenette, and any auxiliary food preparation spaces, as of July 25, 2025. No additional deficiencies were identified. 3. Training will be provided for all Maintenance staff and Dietary staff regarding the updated policy on an approved method of attachment and/or alignment marking. This will be monitored during the monthly kitchen rounds.		10/01/2025

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K0324 SS = D	Continued from page 5 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. These deficient findings could an isolated impact on the residents within the facility. The findings include: On 07/23/2025 at 12:20pm, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of attachment and/or an alignment mark to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment device and alignment mark are required for each gas operated and deep fat fryer cooking device. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0324	Continued from page 5 4. The Maintenance Director or designee will audit the kitchen hood fire suppression system and related fire safety equipment monthly for a period of at least 3 (3) months. Audit results will be reviewed by the Safety Committee at each monthly meeting, and the committee will recommend any changes in frequency or scope of audits as needed.	
K0346 SS = D	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	K0346	Upon notification of the deficiency, the facility added to the fire evacuation plan that the State Fire Marshall will be notified if the fire alarm system experiences an outage lasting longer than 4 hours in a 24-hour period. The Maintenance Director was responsible for implementing these corrections. 2. Training will be provided for all Maintenance staff regarding notification of State Fire Marshall when the fire system is experiencing an outage of greater than four hours in a 24-hour period. 3. The Director of Maintenance will review the fire evacuation policy annually and provide any updates or revisions as applicable and will follow up with the	10/01/2025

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K0346 SS = D	Continued from page 6 This STANDARD is NOT MET as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to implement a fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/23/2025 at 10:36am, it was revealed by a review of available documentation that the facility could not provide a copy of an Out of Service Policy indicating that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire alarm outage lasting longer than four (4) hours in a 24-hour period. Names and numbers for AHJ is required to be listed in policy were missing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0346	Continued from page 6 Safety Committee as needed.		
K0353 SS = E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by:			K0353	All items stored within 18 inches of the sprinkler heads in the central supply room and laundry storage area were immediately removed or repositioned to maintain the required clearance on 7/23/2025. The Maintenance Director was responsible for implementing these corrections. The Maintenance Director conducted a comprehensive audit of all storage rooms, resident care areas, supply closets, and maintenance spaces as of September 19, 2025 to ensure no other areas were affected by improper storage near sprinkler heads. Training will be provided for all maintenance staff, environmental services, and supply management team members regarding the requirement to have items stored greater than 18” from fire sprinkler heads. Maintenance will audit facility storage rooms x times to verify compliance. The Maintenance Director or designee will audit all storage areas for sprinkler clearance weekly for a period of at least three (3) months. The QAPI/Safety Committee will review audit results monthly and recommend any changes in frequency or scope of audits as needed.		10/01/2025

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K0353 SS = E	Continued from page 7 Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 07/23/2025 at 12:24pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in storage room 003A An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0353				
K0354 SS = D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility did not properly implement a fire watch protocol for when the fire alarm system is out of service for more than 10 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 19.3.5.1, 9.7.5, and NFPA 25 2017 edition, Installation, Test and Maintenance of Water Based System, section 15.5.2. This deficient finding could have an isolated impact on the residents within the		K0354	Upon notification of the deficiency, the facility added to the fire evacuation plan that the State Fire Marshall will be notified if the fire sprinkler system experiences an outage lasting longer than 10 hours in a 24-hour period. The Maintenance Director was responsible for implementing these corrections. 2. Training will be provided for all Maintenance staff regarding notification of State Fire Marshall when the fire sprinkler system experiences an outage lasting longer than 10 hours in a 24-hour period. 3. The Director of Maintenance will review the fire evacuation policy annually and provide any updates or revisions as applicable and will follow up with the Safety Committee as needed.		10/01/2025	

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K0354 SS = D	Continued from page 8 facility. Findings include: On 07/23/2025 at 11:23am, it was revealed by documentation review that the facility failed to provide an out of service policy that indicated that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire sprinkler system outage lasting longer than ten (10) hours in a 24-hour period. Names and numbers for AHJ is required to be listed in policy were missing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0354				
K0355 SS = D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/23/2025 at 11:42am, it was revealed by observation that the fire extinguisher in the North Dining Room was blocked by a serving cart. After discussion with Maintenance Director, this is an occurrence that is common during meal service. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0355	The alleged deficiencies identified during the life safety survey have been corrected as of July 23, 2025. All blocked or inaccessible portable fire extinguishers were immediately cleared of obstructions, and signage was verified to be visible. The Maintenance Director was responsible for implementing these correction. The Maintenance Director conducted a comprehensive audit of all fire extinguisher locations throughout the facility—including resident care areas, common spaces, storage rooms, and service corridors—as of July 25, 2025, to ensure no other areas were affected. Fire extinguishers will be check for blockage during the monthly fire extinguisher audit in TELS. Training will be provided for all maintenance staff and housekeeping team members regarding the protocol that fire extinguishers should not be blocked or inaccessible. The Maintenance Director or designee will audit fire extinguisher accessibility and signage weekly for a period of at least three (3) months. The QAPI/Safety Committee will review these results monthly and recommend any changes in frequency or scope of audits needed.		10/01/2025	
K0372 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier		K0372	The alleged deficiencies identified during the life safety survey have been corrected as of July 30, 2025. All penetrations and gaps in the smoke barrier walls were sealed using UL-listed firestop materials. The Maintenance Director was responsible for implementing		10/01/2025	

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K0372 SS = F	Continued from page 9 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/23/2025 at 11:27am, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors south lower level hallway and west lower level hallway An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0372	Continued from page 9 the corrections. Areas of the building or equipment that could have been similarly affected were assessed. The Maintenance Director conducted an audit of all smoke barrier walls, doors, and penetrations throughout the facility—including resident care areas, service corridors, and mechanical rooms—as of September 19, 2025 to ensure no other areas were affected. Training will be provided for all Maintenance staff and Environmental Services team members regarding the updated policies, safety protocols, and inspection routines on the requirement that all penetrations and gaps in the smoke barrier walls were sealed using UL-listed firestop materials. The Maintenance Director or designee will audit all smoke barrier walls and doors, including penetrations and door closers, monthly for a period of at least three (3) months. The QAPI/Safety Committee will review these audit results and recommend any changes in frequency or scope of audits as needed.		
K0541 SS = D	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided			K0541	The third floor laundry chute was corrected as of 07/25/2025. The third-floor laundry chute door was immediately secured by installing a compliant self-closing device and a positive latching mechanism to ensure the door remains closed when not in use. The Maintenance Director was responsible for implementing these corrections. Areas of the building or equipment that could have been similarly affected were assessed. The Maintenance Director conducted a comprehensive audit of all laundry chute doors and other fire-rated doors throughout the facility as of 07/25/2025 to ensure no other areas were affected. Training will be provided for all maintenance staff regarding the requirement for a functioning latch on all laundry chute doors. Laundry chute doors will be		10/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/23/2025	
NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD , WOODBURY, Minnesota, 55125			
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K0541 SS = D	Continued from page 10 with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to secure the laundry chute door per NFPA 101 (2012 edition), Life Safety Code section 19.5.4.1. These deficient findings could have an isolated impact on the residents within the facility. On 07/23/2025 at 11:38am, it was revealed by observation that the laundry chute door located on the third floor was missing self-closing device and/or a device to secure chute door in the closed position. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0541	Continued from page 10 inspected monthly in TELS. The Maintenance Director or designee will audit all laundry chute doors, monthly for a period of at least 3 months. The QAPI or Safety Committee will review these results and recommend any changes in frequency or scope of audits.			
K0712 SS = D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012		K0712	The fire drill(s) not meeting documentation requirements were immediately corrected to include the year along with the date of completion. The maintenance director completed a full audit of all fire drill documentation to validate the full date including day, month and year were documented. Training will be provided for all maintenance staff on proper documentation of fire drills including a full day, month and year of the drill. The Maintenance Director or designee will audit fire drill logs and observe fire drills monthly for a period of at least three (3) months.		10/01/2025	

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K0712 SS = D	Continued from page 11 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/23/2025 at 11:19am, it was revealed by a review of available documentation that fire drills did not meet requirements. Fire drill documentation was incomplete due to lack of full dates. Many of the dates on documents were incomplete. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0712				
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/23/2025 at 11:01am, it was revealed by review of available documentation the required annual door		K0761	The required annual door inspection documentation that covered the 13 points of the door inspection was immediately implemented. All fire doors throughout the facility were inspected using the new 13-point audit form by 9/22/25. Training will be provided for all maintenance staff and relevant contractors regarding the updated fire door inspection policy, safety protocols, and inspection routines. Door inspections will occur monthly as part of our TELS preventative maintenance program. The Maintenance Director or designee will audit fire door inspections and documentation monthly for a period of at least 3 months. The QAPI Committee will review these audit results and recommend any changes in frequency or scope of audits as needed.		10/01/2025	

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K0761 SS = F	Continued from page 12 inspection documentation that covered the 13 points of the door inspection was not available at the time of the survey.		K0761				
K0914 SS = F	An interview with the Maintenance Director verified these deficient findings at the time of discovery.						
	Electrical Systems - Maintenance and Testing		K0914	All entries with missing dates were immediately re-inspected and updated with completed dates.		10/01/2025	
	CFR(s): NFPA 101						
	Electrical Systems - Maintenance and Testing			All subsequent entries were verified for the correct date/year format on 9/19/2025.			
	Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.			Training will be provided for all maintenance staff on the requirements of receptacles at patient bed locations and testing after initial installation, replacement or servicing.			
	6.3.4 (NFPA 99)			The Maintenance Director or designee will audit the Receptacle Testing Logbook for 3 months to ensure proper completion.			
	This STANDARD is NOT MET as evidenced by:						
	Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility.						
	Findings include:						
	On 07/23/2025 at 11:12am, it was revealed by review of available documentation the required annual receptacle inspection documentation with dates to reflect inspection was not available at the time of the survey.						
	An interview with the Maintenance Director verified these deficient findings at the time of discovery.						

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K0914 K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/23/2025 at 11:48am, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; 1) Multi-plug adapter in use in patient room 214. In this example, both heating and cooling appliances were in use in this patients room An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0914 K0920	The multi-plug adapter in patient room 214 was immediately removed. The Maintenance Director conducted a comprehensive audit of the facility to ensure no multi-plug adapters were present 7/25/25. Training will be provided for all maintenance staff on the requirements of electoral equipment-power cords and extension regulations. Maintenance will audit for power cords, multi-plug adapters and extension chords monthly during. The Maintenance Director or designee will audit the facility monthly y for 3 months to ensure multi-plug adapters are not in use. The QAPI Committee will review these results and recommend any changes in frequency or scope of audits.		10/01/2025



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 18, 2025

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

RE: CCN: 245235

Cycle Start Date: July 24, 205

Dear Administrator:

On October 28, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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Electronically delivered

November 18, 2025

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

Re: Reinspection Results
Event ID: D6YU-H2

Dear Administrator:

On October 28, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 24, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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