Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2024

Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, MN 55077

RE: CCN: 245320
Cycle Start Date: March 5, 2024

Dear Administrator:

On March 12, 2024, we informed you that we may impose enforcement remedies.

On March 14, 2024, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 5, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 5, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 5, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 5, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Woodlyn Heights Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 5, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care

deficiencies (those preceded by a "F" and/or an "E"tag), i.e., the plan of correction should be directed to:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 5, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	**2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077**

(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
E 000	Initial Comments On 3/11/24 to 3/14/24, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. Woodlyn Heights Healthcare Center was found not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		4/7/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/05/2024

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 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.

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E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource	E 041		

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E 041	Continued From page 2 Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on documentation review and staff	E 041	The Woodlyn Heights Senior Living	

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E 041	Continued From page 3 interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/13/2024 between 10:15 a.m. and 2:15 p.m., it was revealed by a review of available documentation that no documentation was presented to confirm that 36 months - 4-hour load-bank testing is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	Facility corrected the deficiency. The Regional Maintenance Director had Third party contractor perform 4 hour load bank test and supply proper documentation of inspection. A comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
F 000	INITIAL COMMENTS On 3/11/24 to 3/14/24, a standard recertification survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were also completed. Woodlyn Heights Care Center was found not compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaints were reviewed with no associated deficiencies issued: - H53201444C (MN97015) - H53201549C (MN97953) - H53201550C (MN97955) - H53201543C (MN97933)	F 000		

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F 000	Continued From page 4 - H53201542C (MN98105) - H53201544C (MN98160) - H53201548C (MN98306) - H53201545C (MN100727 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 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 assess 2 of 2 residents (R10, R27) reviewed for the ability to self-administer medications (SAM). Findings include: R27's quarterly Minimum Data Set (MDS) dated 1/23/24, indicated R27 was cognitively intact and had no issues with mood or behavior. MDS indicated R27 needed assistance to set up her meals, supervision with showers, and was independent with dressing, toileting, bathing, and	F 554	F (F554) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for	4/7/24

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F 554	Continued From page 5 transfers. R27's Medical Diagnosis report printed 3/13/24, indicated diagnoses of multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), unspecified psychosis (a mental disorder characterized by a disconnection from reality), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body), generalized anxiety, idiopathic chronic gout (a condition caused by too much uric acid in the body which causes swelling and pain around the affected joint), chronic pain, type II diabetes (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), hypertension (high blood pressure), major depression, and personality disorder. R27's electronic medical record lacked an order for diclofenac (medication used to treat mild and moderate pain) and/or Calazinc (medication used to temporarily protect and help manage moisture and relieve minor skin irritations) and documentation about the completion of a SAM assessment for these medications. During an observation and interview on 3/11/24 at 4:21 p.m., a tube of Calazinc Body lotion and a tube of diclofenac sodium were observed in R27's bathroom. R27 stated she applied the Calazinc cream to her bottom and used the diclofenac sodium 1% as the label indicated three times a day for shoulder pain. During an interview on 3/13/24 at 11:10 a.m. registered nurse (RN)-F stated R27 medications	F 554	procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (554), Resident Self-Admin Meds-Clinically Appropriate. Woodlyn Heights Senior Living corrected the deficiency by reviewing R10 for self-administration of medication. R10 deemed not appropriate for self-admin and all medications were removed from room. R27 discharged from facility. All residents reviewed, and any resident that wish to self-administer medications, a SAM assessment was completed by 4/6/2024. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses and TMAs were educated on April 2nd and 3rd or prior to their next scheduled shift on the Self-Administration of Medication Policy by Director of Nursing. 3. The DON and/or designee will audit self-administration of medications by observing 5 medication passes 3x week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks and then as needed to ensure continued compliance.	

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F 554	Continued From page 6 were administered by the nurses and did not have an order to self-administer her medications. During an interview on 3/13/24 at 12:15 p.m. R27 indicated she self-administered the Calazinc and diclofenac and kept both creams in the bathroom. R27 stated she asked the nurses for the Calazinc cream when her tube was almost empty, and used the cream as needed for her bottom. The diclofenac had a pharmacy label with R27's information and prescription directions. R27 stated she applied the diclofenac cream three times a day for pain to her shoulders and left hip. During observation and interview on 3/13/24 at 1:10 p.m., nurse manager/registered nurse (RN)-H verified R27 didn't have a SAM assessment and was not aware R27 was using the creams. RN-H verified R27 had tubes of Calazinc and diclofenac cream in the bathroom. R27 informed RN-H she had been self-administering both creams for "as long as she can remember." R27 stated "I receive the diclofenac cream and other medications in the mail and gave the package to the nurse on duty. The nurses kept the pills and gave me the creams." During observation and interview on 3/13/24 at 1:20 p.m., RN-F confirmed to RN-H the medicated cream arrived via mail and the nurses had given the diclofenac tubes to R27. During interview on 3/13/24 at 2:04 p.m. director of nursing (DON) stated a SAM assessment needed to be completed to assess residents' ability to self-administer any medication, including medicated creams.	F 554	4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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F 554	Continued From page 7	F 554		

R10

R10's quarterly Minimum Data Set (MDS) dated 12/26/23, included the following diagnoses for R10: chronic obstructive pulmonary disease (progressive lung disease), heart failure, hypertension (high blood pressure), diabetes, metabolic encephalopathy (problem in the brain caused by a chemical imbalance), and macular degeneration in both eyes (loss of vision). The MDS indicated that R10 has vision which was moderately impaired - limited vision.

R10's Brief Interview for Mental Status (BIMS) assessment, dated 10/9/23, moderate cognitive impairment.

During observation and interview on 3/11/24 at 4:54 p.m., R10 was observed sitting in her recliner in her room. She had a bedside table immediately to the left of her recliner. R10 stated she was taking her "4 o'clock" medications". R10 had empited them onto the bedside table, from the plastic medication cup, to spread them out "so I can see them a little." R10 indicated that the nurse brought them in "a while ago but I wasn't ready to take them, so they left them with me ...I always take them though". R10 was not able to identify the medication tablets on the table. R10 stated "the big white ones I call the horse pills because they are so big." R10 was not able to state what the medications were for. R10's nebulizer was on a table to the right of her recliner, within her reach. It contained a clear liquid substance in the nebulizer chamber. R10 was not able to identify what the liquid was but

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F 554	Continued From page 8 stated she does her nebulizer herself. R10 indicated "the nurse sets it up for me so I can use it when I need it ....I use it when I get a heaviness in my chest ....I am able to see the black button to turn the machine on and off ....they [staff] don't usually watch me when I use it ...they just put the solution in it so I can use it whenever I want." R10 took the oral tablets while surveyor was in the room during interview. There was no staff present while R10 was taking her oral medication. R10's medication self-administration safety screen, dated 7/7/23, indicated R10 may not self-administer medications. There is a note indicating "not a candidate for SAM." R10's care plan, printed 3/13/24, lacked documentaion R10 was appropriate for self-administration of medications. During interview on 3/14/24 at 2:09 p.m., registered nurse (RN)-D stated that R10 is not appropriate for self-administration of medications. They stated that she likes to put the strap on for the mask herself, but they stand in the room with her during the nebulizer treatment. RN-D stated that she sometimes "just holds the mask to her face instead of putting the strap on." RN-D stated due to multiple reasons, she needs supervision with oral medications, and they should not be on the table for her to take and staff should stay with her during administration. During interview on 3/14/24 at 2:15 p.m., nurse manager (NM)-E stated R10 would not be appropriate for self-administration of medications. NM-E stated They would expect nurses to stay either in the room or right outside the door (where they can still see her) to observe her use her	F 554		

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F 554	Continued From page 9 nebulizer. NM-E verified that R10's SAM indicated she was not appropriate for self-administration of medication. During interview on 3/14/24 at 2:26 p.m., director of nursing (DON) indicated that an assessment needed to be done prior to self-administration of medication to assess if a resident is appropriate. DON verified that R10 should not take medications without being observed and should not be doing nebulizer treatments by herself. A facility policy on self-administration of medication was requested and not provided.	F 554		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State	F 645		4/7/24

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F 645	Continued From page 10 intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).	F 645		

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F 645	Continued From page 11 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASARR) was conducted, documented, and retained to ensure mental health needs were appropriately addressed or provided for 2 of 2 residents (R4, R27) reviewed for PASARR. Findings include: R4 R4's annual Minimum Data Set (MDS) dated 1/16/24, identified R4 with admission to facility on 3/10/21 and diagnoses of bipolar disorder (a mental health condition that causes extreme mood swings between emotional highs and lows), depression, diabetes, and delusional disorder. R4's initial Pre-Admission Screening (PAS) results and attached letter from Senior Linkage Line, dated 3/10/21, indicated "The Senior Linkage Line forwarded the PAS to the county/managed care organization for processing. The PAS is not final until the lead agency sends documentation to the nursing facility." The letter went on to list a lead agency and phone number for the facility to follow up with. R4's entire medical record was reviewed and lacked evidence a final determination had been	F 645	F 645 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 645, PASARR Screening for MD & ID. Woodlyn Heights Senior Living corrected the deficiency by ensuring R4 PASARR was completed on 3/9/2021. R27 no longer resides in the facility. All resident PASARRs were reviewed for accurate completion on 04/12/2024 by the Executive Director or designee. 2. To prevent future occurrences of this	

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F 645	Continued From page 12 received and/or evaluated by the county or managed care program as directed by the PAS (dated 3/10/21). During interview with medical records clerk (MRC) on 3/12/24 at 11:46 a.m., MRC reviewed R4's Level I PAS document MRC and stated, "looks like she had the Level I. [I] Can't see if she got the Level II results. From the looks of it this is incomplete." MRC stated she was responsible for following up on the Level II's but, "I gave up after doing it a few times." MRC stated, "I know it needs to get done." During interview with administrator on 3/12/24 at 12:23 p.m., the administrator stated his expectation of staff to complete and follow up on PASARRs. Administrator stated, "[it is] important to have a completed PASARR done to keep them [residents] assessed for appropriate services if they trigger [or are] needing it." R27 R27's quarterly Minimum Data Set (MDS) dated 1/23/24, indicated R27 was cognitively intact and had no issues with mood or behavior. R27's Medical Diagnosis report printed 3/13/24, indicated diagnoses of multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), unspecified psychosis (a mental disorder characterized by a disconnection from reality), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body),	F 645	issue, the Social Services department was trained in the Accura process for handling PASARRs by 4/12/2024 from Accura's Social Services Director. Woodlyn Heights updated its PASARR policy accordingly. The Executive Director and/or designated personnel will conduct audits as follows: 3 resident PASARRs weekly for 4 weeks, 2 resident PASARRs weekly for 4 weeks, 1 resident PASARR weekly for 4 weeks, followed by random audits to maintain compliance. 3. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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F 645	Continued From page 13 generalized anxiety, major depression, and personality disorder. R27's Pre-Admission Screening (PAS) results and attached letter from Senior Linkage Line, dated 5/22/23, indicated the Senior LinkAge line received and processed a pre-admission screening (PAS/OBRA Level I). The letter indicated Senior LinkAge Line made a referral for mental illness OBRA level II to lead agency. The letter went on to list a lead agency and phone number for the facility to follow up with. R27's medical record was reviewed and lacked evidence a final determination had been received and/or evaluated by the county. During interview on 3/13/24 at 11:23 a.m., MRC indicated the facility did not follow up the results of the PASARR with the lead agency. During interview on 3/14/24 at 10:05 a.m. administrator stated it was the medical records clerk's responsibility to ensure the PASARR was completed. A policy on PASARR was requested but not received.	F 645		
F 684 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	F 684		4/7/24

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F 684	Continued From page 14 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control techniques were implemented during wound care for 2 of 2 residents (R11, R49) who were reviewed for wound care. In addition, the facility failed to comprehensively assess, monitor, and provide necessary care for 1 of 1 residents (R2) with a intrathecal baclofen pump. Findings include: R11 R11's quarterly Minimum Data Set (MDS) dated 2/26/24, identified R11 with intact cognition, diagnoses of diabetes, chronic kidney disease, chronic obstructive pulmonary disease (debilitating lung disease[COPD]), lymphedema (condition that results in swelling of the leg or arm due to blockage in the lymphatic system which is part of the immune system), anxiety, depression, and cellulitis of right lower leg (potentially serious bacterial skin infection). In addition, R11 on oxygen. R11's Diagnosis List, printed 3/14/24, identified R11 with non-pressure chronic ulcer of right lower leg with fat layer exposed, and history of methicillin resistant staphylococcus aureas infection (infection resistant to many antibiotics), and deep vein thrombosis (deep tissue blood clots). R11's physician orders, dated 12/9/23, directed staff to perform, "Bilateral leg: apply Aquaphor	F 684	F (F684) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (684), Quality of Care. Woodlyn Heights Senior Living corrected the deficiency by providing education to RN-C and RN-A on appropriate infection control technique during dressing changes for R11, R49 and all like residents by the DON on 4/5/2024. Orders for assessing, monitoring, and management of baclofen pump were added to R2 MAR/TARs and care plan on 4/3/2024. 2. To correct the deficiency and to ensure	

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F 684	Continued From page 15 healing ointment, wrap with kerlix, apply ace wrap daily." R11's care plan revised 12/31/22, informed staff of "[R11] has history of infection requiring antibiotics". During observation of R11's wound care with registered nurse (RN)-C on 3/11/24 at 3:44 p.m., RN-C gathered supplies from R11's dresser drawer. RN-C removed four pieces of medical tape from a roll and then adhered them to a bedside nightstand. RN-C removed the dressing from R11's right lower leg using medical scissors that were removed from the dresser drawer. These medical scissors were not wiped down prior to use. RN-C placed a towel under R11's right leg and performed wound care to right leg using uncleaned scissors to trim kerlix wrap and then placed the scissors onto R11's bed sheet. RN-C obtained two of the pieces of medical tape that were attached to the nightstand and secured the dressing. RN-C dated and labeled one piece of medical tape before applying the ace wrap and stockingette. RN-C proceeded to R11's left leg and removed the old compression dressing and ace wrap. RN-C removed the two remaining pieces of medical tape from top of dresser drawer and re-attached them to the handle of R11's wheeled walker which was near the bedside. RN-C sanitized hands and reapplied gloves and picked up the uncleaned scissors from the top of R11's bed sheet and trimmed the old kerlix wrap from R11's left leg. RN-C then lifted R11's left leg and placed the same towel used for R11's right leg wound care procedure, and then set R11's exposed left leg on top of it. RN-C proceeded with wound care to R11's left leg and put the sterile kerlix wrap on top of the unclean towel prior to	F 684	the problem does not recur all licensed nursing staff had competency training on appropriate infection control technique during dressing changes and Baclofen Intrathecal Pump on April 2nd and 3rd or prior to their next scheduled shift by DON. 3. The DON and/or designee will audit 3 wound care treatments for appropriate infection control techniques 3x a week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks, and then as needed to ensure continued compliance. The DON and/or designee will audit MAR/TARs and Care Plan of all residents with baclofen pump for appropriate assessments, monitoring, and management of pump 3x a week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks, and then as needed to ensure continued compliance. 4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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F 684	Continued From page 16 wrapping R11's left leg. RN-C wrapped the kerlix from the ankle to below the knee and applied the two pieces of medical tape to top of kerlix wrap. RN-C then completed wound care with wrapping the ace wrap on top of the kerlix and applying the stretch wrap from ankle to knee. During interview with RN-C on 3/11/24 at 6:05 p.m., immediately after R11's wound care, RN-C stated, "Scissors should be cleaned between left leg and right leg [wound care]. Common sense [sic]." And "I used the same towel for both legs." In addition, RN-C stated, "The paper [medical] tape was attached to the night table which I did not make sure was wiped down with cleaner or a wipe. I also moved two pieces of paper [medical] tape from the nightstand to the handle of the walker which was not cleaned prior to me using it." R49 R49's quarterly MDS dated 12/19/23, identified R49 with moderate cognitive impairment, diagnoses of epilepsy, combined congestive and diastolic heart failure, venous ulcer of left lower extremity, bipolar disorder (a serious mental illness characterized by extreme mood swings), depression, COPD and oxygen use. In addition, R49 was listed as receiving hospice services. R49's orders dated 2/10/24 directed staff, "Wound Care: LLE VLU-cleanse wound daily, place crushed doxycycline in wound bed, cover with calcium alginate and wrap with rolled guaze." R49's care plan revised 2/13/24 indicated, "[R49] has an infection of L lower leg trunk requiring antibiotic therapy directory to wound bed."	F 684		

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F 684	Continued From page 17 During observation of R49 wound care with registered nurse (RN)-A on 3/12/24 at 2:04 p.m., RN-A stated R49 "vulnerable to infection". RN-A gathered supplies from R49 dresser drawer. RN-A removed a piece of medical tape from a roll then dated and labeled it with a permanent marker. RN-A then tore the medical tape off and adhered it to the top of the uncleaned drawer. RN-A performed wound care to left lower leg by removing old dressing, applying cleanser to wound bed, applying medicated powder, and dressing to wound bed, applying kerlix, and then applied the labeled medical tape to dressing. During interview with RN-A immediately after the procedure, RN-A stated, "tape should not be touching or attached [sic] to the top of the drawers. [I] do not know if it [dresser top] has germs on it and I did not clean it [dresser top] before attaching the tape. Should not do that." During interview with director of nursing (DON) on 3/13/24 at 1:37 p.m., DON stated, "disappointment" in staff placing medical tape on uncleaned surfaces and, "I expect my staff to utilize proper infection control techniques including wiping down scissors before and after use". DON stated the sharing of a single towel from one leg to another while performing wound care is, "not acceptable infection control." DON stated, "These residents [R11, R49] are at risk for infection and both have been battling long term infections and wound care. Placing the kerlix on a towel and then using the kerlix to wrap her leg [R11] is not using acceptable infection control techniques." And "they [nurses] know better." INTRATHECAL BACLOFEN PUMP	F 684		

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F 684	Continued From page 18 R2'S quarterly Minimum Data Set (MDS), dated 12/12/23, identified R2 had intact cognition. Diagnoses included: progressive neurological conditions, multiple sclerosis, anemia, neurogenic bladder, malnutrition, pressure ulcer of unspecified part of back-stage 3, pressure ulcer of right lower back-stage 2. MDS lacked identification in the diagnosis of presence of other specified device. Section O: special treatment and program of the MDS was marked under Z1, indicated resident had "none of the above". MDS further indicated, R2 needed set up for eating. R2 was dependent for all other activities of daily living (ADLs) including dressing and bed mobility. R2 had an indwelling foley catheter and always incontinent of bowels. MDS lacked identification of diagnosis of presence of other specified device [baclofen intrathecal pump]. R2's Order Summary Report, printed 3/14/24, included the following diagnoses: presence of other specified devices, multiple sclerosis (autoimmune disorder which damage the insulating covers of the nerve cells in the brain and spinal cord), reduced mobility, pressure ulcer of unspecified part of back-stage 3, and pressure ulcer of right lower back-stage 2. The report lacked evidence of an order for the baclofen pump which indicated the placement, dose, and rate of medication R2 received daily. The report lacked evidence of the last fill of the pump or when it is due to be filled. R2's medication administration record for March 2024, printed 3/13/24, indicated the following orders: -[R2] may develop the following withdrawal symptoms when the battery for the internal	F 684		

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(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
F 684	Continued From page 19 intrathecal baclofen pump [surgically implanted pump that delivers medication directly to the fluid surrounding the spinal cord] runs down or not working: baseline muscle spasticity, itching without a rash, twitching, low blood pressure, abnormal sensations, and/or other life threatening signs like high fever, confusion, rebound spasticity, or muscle rigidity. Administer oral baclofen PRN as ordered. Notify the provider and contact the clinic of neurology [provider name and contact information included] as needed for baclofen pump with a start date of 5/1/22 - baclofen tablet (medication for muscle spasms) 10 milligrams (mg) give 1 tablet by mouth every 4 hours as needed for baclofen withdrawal. [R2] may develop the following withdrawal symptoms when the battery for the internal intrathecal baclofen pump runs down or not working: baseline muscle spasticity, itching without a rash, twitching, low blood pressure, abnormal sensations, with a start date of 5/5/2022 - Complete Body Audit Assessment in PCC Weekly on Tuesdays PM. Weight and full vitals one time a day every Tue for body audit must complete regardless if resident refuses shower with a start date 7/11/2023 The medication administration record lacked evidence of monitoring of the intrathecal baclofen pump. R2's care plan, printed 3/14/24, indicated [R2] "potential for pain with need for medication management R/T history of surgery and history of pressure ulcer /multiple skin issues." Intervention/task included the following: -"intrathecal baclofen pump: simple continuous to deliver 27.65 micrograms (mcg)/day".	F 684		

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	245320	A. BUILDING _____ B. WING _____	C 03/14/2024

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F 684	Continued From page 20 - "Offer non-pharmacological interventions for pain relief such as music, repositioning, massage Etc." - "Observe/document verbal and non-verbal s/sx of pain: Resident reports pain, Weight changes, protective behavior, guarding behavior, facial mask, irritability, self-focusing, restlessness, depression, Atrophy of involved muscle group, Changes in sleep pattern, Fatigue, Fear of re-injury, Reduced interaction with people, altered ability to continue previous activities, Sympathetic mediated responses (e.g., temperature, cold, changes of body position, hypersensitivity), Anorexia." - "Report pain or requests for analgesics to nurse" R2's care plan lacked indication for baclofen pump, interventions needed, how to monitor, placement of the pump, or management of pump. During observation and interview on 3/11/24, at 12:21 p.m., R2 was observed lying in bed. R2 stated she has a baclofen pump that manages the pain from the muscle spasms from the multiple sclerosis. R2 indicated that it was implanted in her abdomen and had since before moving to the facility. R2 further indicated that staff do not monitor or look at the pump. On 3/11/24 at 11:14 a.m., registered nurse (RN)-F indicated that they were currently working with R2 and frequently worked with R2. RN-F verified they are familiar with her needs and cares. RN-F stated that R2 does not have any type of implanted pump. RN-F stated, "it would be important for me to know if a resident did.". Upon review of the electronic medical record (EMR) and meeting with R2, RN-F verified that R2 does	F 684		

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F 684	Continued From page 21 have an intrathecal baclofen pump. They indicated that they were unaware of this. RN-F verified they do not monitor the site or know who fills the pump or when it was last filled. RN-F verified they do not know the current dose of baclofen R2 gets and if the resident was transferred to another facility, this information would be missing. On 3/13/24 at 11:29 a.m., nurse manager (NM)-E indicated that they are familiar with R2. NM-E verified that there are no current orders for the baclofen pump listed on current medication list with current dose. They stated they monitor for withdrawal, would administer as needed (PRN) baclofen, and notify the provider. NM-E indicated they should be monitoring the baclofen pump site. NM-E verified the nurses "really don't do anything with the pump" and it should it monitored. NM-E stated the company who fills the pump came on a Sunday evening to fill the pump in December. NM-E indicated they were unsure if this was documented. NM-E verified that if the baclofen dose is not listed on the orders, another facility would not know what the current rate is if the resident was transferred. On 3/13/24 at 2:31 p.m., NM-E provided documentation of baclofen pump fill from Medtronic. The report indicated the baclofen pump was refilled on 7/18/23 and the setting currently set at baclofen 27.65 micrograms(mcg)/day. The report indicated the next fill currently scheduled for 1/9/24. On 3/18/24, a copy of Medtronic report from baclofen fill was provided. The report indicated R2's baclofen pump was filled on 1/9/24 at a current rate of 27.65 mcg/day with the next fill	F 684		

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F 684	Continued From page 22 date of 6/25/24. On 3/13/24 at 3:29 p.m., nursing assistant (NA)-D verified they are familiar with R2. NA-D verified they frequently are assigned to that wing and care for R2. They verified they are familiar with her current care level. NA-D indicated that she needs assistance with all cares. They stated that R2 does not have a baclofen pump. Upon review, NA-D indicated they would expect this information to be readily available in the computer [EMR] and on the Kardex. NA-D indicated this is important information for everyone who cares for the resident to know. On 3/14/24 at 8:01 a.m., NA-E verified that they worked with R2 within the last week. NA-E verified they are familiar with the needs and care level of R2. NA-E stated they are not aware of R2 having a baclofen pump. NA-E indicated they would expect this to be in report and passed along as this would be important to be monitored. On 3/14/24 at 11:17 a.m., director of nursing (DON) indicated that it is important that staff is aware of R2 intrathecal baclofen pump. DON verified that it needs to be monitored. DON verified there is no dose listed on the current orders for the baclofen pump. DON verified there is no monitoring in place for the pump. On 3/14/24 at 1:51 p.m., administer stated that it is important that we monitor an intrathecal baclofen pump. He further indicated that they would provide education as needed for staff [in regards to intrathecal baclofen pumps]. Facility policy on General Information Prevention and Control-Nursing Standards updated	F 684		

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F 684	Continued From page 23 10/5/2023 state, "Reducing and/or preventing infections through indirect contact requires the decontamination (i.e., cleaning, sanitizing, or disinfecting an object to render it safe for handling) or resident equipment, medical devices, and the environment." In addition, the facility Infection Control Manual updated 10/5/2023, documented, "If you use scissors-wipe them down with a disinfectant wipe after use". A facility policy on accuracy of records was requested but not provided.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide assistance for hearing appliances for 1 of 1 (R17) residents reviewed who had bilateral hearing aides. Findings include:	F 685	F (F685) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement	4/7/24

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F 685	Continued From page 24 R17's quarterly Minimum Data Set (MDS) dated 1/16/24, indicated R17 admitted to the facility on 1/7/22, and had moderate cognitive impairment, diagnoses of Parkinson's (progressive disorder that affects the nervous system and parts of the body controlled by the nerves), encephalopathy (brain disorder that affects its function), chronic pain, anxiety, dementia, diabetes and depression. In addition, R17 received hospice services. R17's Care Area Assessment (CAA) dated 5/22/23, indicated R17 triggered for communication impairment. R17's care plan (CP) dated 1/7/22, indicated, "[R17] had impaired hearing compensated well with use of bilateral hearing aides". CP intervention include, "[R17] requires the following hearing appliances: (hearing aides bilateral)". R17's Kardex with print date of 3/12/24, informed care staff of "Communication" section stating, "[R17] requires the following hearing appliances: (hearing aides bilaterally). During observation and interview on 3/12/24 at 7:51 a.m., R17 was laying in bed positioned on her back. R17 did not have hearing aides in. R17 stated, "I don't know where they [hearing aides] are". During observation and interview on 3/12/24 at 2:39 p.m., R17 was laying in bed positioned on her back. R17 stated, "I don't know where they [hearing aides] are. They are supposed to be at the front desk." Registered nurse (RN)-A stated she was familiar with R17 care and needs and stated, "[R17 hearing aides] are not in nursing	F 685	by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (685), Treatment/Devices to Maintain Hearing/Vision. Woodlyn Heights Senior Living corrected the deficiency by immediately locating R17 hearing aides. Hearing aides were non-functional. Audiologist contacted for hearing aide replacement/repairment on 4/4/24. R17 offered a pocket talker amplifier until hearing aids are repaired/replaced. All residents with hearing devices were reviewed for appropriate management. Those unable to manage hearing devices independently are now stored in medication cart and application is managed by nurse on 4/4/2024. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on Care of Residents with Hearing Devices, storage and application on April 2nd and 3rd or prior to their next scheduled shift by DON.	

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F 685	Continued From page 25 cart. Could be in the nightstand, bathroom or around her room. The aide or nurses should be putting them in for her. If she refuses we should document. I do not know anything about her hearing aides. I have not put them in for her." During interview with R17's family member (FM)-A (who is also the primary emergency contact for R17) on 3/14/24 at 2:40 p.m., FM-A stated, "Yes. [R17] has hearing aides. Had them for years." FM-A also stated, "She [R17] needs them to help her understand what people are saying to her. She can be a little isolated feeling if she doesn't hear well. They [staff] should at least put a battery in them and offer it to them [sic] but I doubt they do. The hearing aides are never in her ears when I visit." During observation and interview on 3/12/24 at 2:44 p.m., nursing assistant (NA)-D stated he was familiar with R17 care needs. (NA)-D looked around R17 room and found two hearing aides in a nightstand drawer along with several small button batteries. "I expect to have it [information about hearing aides] on my Kardex to tell me. I would be responsible for putting [them in]." NA-D stated he never put hearing aides in for R17. During interview with NA-A on 3/14/24 at 7:38 a.m., NA-A stated she was familiar with R17 care needs and, "if Kardex says they [residents] are having hearing aides I would look for them in the room." NA-A stated she had never put hearing aides in R17. During interview with NA-C on 3/14/24 at 8:05 a.m., NA-C stated, "[R17] hearing [sic]gotten worse progressively." And "I have no clue if she has the hearing aides. I have never seen hearing	F 685	3. The DON and/or designee will audit all residents with hearing devices for appropriate application, storage, and function of device 3x a week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks, and then as needed to ensure continued compliance. 4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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F 685	Continued From page 26 aides [for R17]. It [hearing aides] should be on my Kardex." Also, "I have been here almost two years and have never seen those hearing aides." During interview with NA-C on 3/14/24 at 8:05 a.m., NA-C stated, "[R17]'s hearing [sic] gotten worse progressively." And, "I have no clue if she has the hearing aides. I have never seen hearing aides for [R17]. It [hearing aides] should be on my Kardex." Also, "I have been here almost two years and have worked with [R17] and have never seen those hearing aides." During interview with director of nursing (DON) on 3/14/24 at 1:02 p.m., DON stated, "hearing is important for her [R17] quality of life." Facility policy on hearing aides was requested but not provided.	F 685		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen therapy was appropriately administered as well as provide Continuous Positive Airway Pressure ([CPAP]-ventilation machine that administers air via an	F 695	F (F695) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does	4/7/24

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F 695	Continued From page 27 external device at a predetermined level of pressure) therapy for 1 of 1 residents (R47) reviewed for respiratory care. Findings include: R47's quarterly Minimum Data Set (MDS) dated 2/27/24, indicated R47 had intact cognition with no behaviors present. The MDS indicated that R47 received oxygen therapy but did not use a CPAP. The MDS indicated R47 required staff assistance for bathing, dressing, and bed mobility. The facility Standing Orders for Skilled Nursing Facilities dated 1/17/22, indicated that nursing staff could initiate and titrate supplemental oxygen from one to four liters per nasal canula (NC) as needed for dyspnea (shortness of breath), hypoxia (oxygen saturation less than 88 percent), or acute angina (chest pain) to keep oxygen saturations at greater than 88 percent. The order indicated that if an increase in supplemental oxygen was needed, nursing staff should "immediately update provider with nursing assessment". The order indicated that nursing staff may wean supplemental oxygen per nursing judgment to maintain oxygen saturations greater than 88 percent. R47's hospital Discharge Summary Report dated 8/7/23, indicated that R47 had presented to the hospital with worsening shortness of breath that was "likely due to several factors" including "lack of wearing a CPAP at night." The report indicated that the hospital providers "strongly recommend" using the CPAP whenever asleep to assist R47 with avoiding future complications.	F 695	not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (695), Respiratory /Tracheostomy Care and Suctioning. Woodlyn Heights Senior Living corrected the deficiency by consulting R47 primary care provider regarding order for CPAP. The provider discontinued CPAP order due to resident refusal on 3/13/2024. All residents with oxygen orders were reviewed for correct flow rate and every shift monitoring of oxygen saturation levels on 4/3/2024. All residents with CPAP orders reviewed for CPAP machine and appropriate administration per physician order on 4/3/2024. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on Respiratory Services: Oxygen and CPAP therapy on April 2nd and 3rd or prior to their next scheduled shift by DON.	

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F 695	Continued From page 28 R47's laboratory results dated 1/4/24, indicated R47's carbon dioxide (a waste product that your body gets rid of with exhale) level was at 34 millimoles per liter (mmol/L) with a reference range of 22-29 mmol/L. R47's Diagnosis Report dated 1/24/24, indicated R47 was diagnosed with obstructive sleep apnea (OSA), depression, heart failure, and chronic obstructive pulmonary disease ([COPD]- incurable lung disease causing breathlessness, frequent coughing, and chest tightness). R47's Order Summary Report dated 2/19/24, indicated an order for as-needed CPAP therapy resumed at previous settings unless otherwise instructed, notify the provider if the resident had increased shortness of breath (SOB), and one liter of oxygen via NC as needed to keep oxygen saturation at greater than 90 percent. R47's medication/ treatment administration record (MAR/TAR) dated 3/1/24- 3/14/24, indicated R47's oxygen saturation and supplemental oxygen level were ordered to be assessed and documented three times a day. The record indicated assessment was missed four times and oxygen was administered at a rate of two liters per minute (LPM) on each assessment except for two occasions (not applicable and three). The correlating oxygen saturations were between 92 percent and 97 percent. The record indicated that the nurse practitioner (NP) was to be notified as needed for increased shortness of breath (SOB) and lacked documentation that it had been completed. R47's oxygen saturation summary dated 3/1/24- 3/14/24, indicated oxygen saturation levels	F 695	3. The DON and/or designee will audit 5 residents with orders for oxygen and CPAP therapy for appropriate administration 3x a week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks, and then as needed to ensure continued compliance. 4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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F 695	Continued From page 29 ranging between 94 and 97 percent, with 92 and 93 percent observed on 3/13/24 and 3/14/24. R47's care plan dated 3/10/24, indicated that R47 had the potential for an altered respiratory status or difficulty breathing related to COPD and heart failure. The care plan indicated that any change in breathing patterns or any signs of difficulty breathing should have been documented and reported to the medical practitioner. The care plan indicated that oxygen should have been given as ordered by the medical practitioner. R47's medical record was reviewed and lack documentation that a CPAP study had been scheduled/attempted to be scheduled and/or R47's refusal of this study. The medical record also lacked documentation indicating need for oxygen increase or that the provider had been updated regarding this increase. During an observation and interview on 3/11/24 at 1:03 p.m., R47 was observed lying in bed with her eyes closed with a NC applied and observed to administer oxygen at a rate of three LPM with her eyes closed. R47 stated that she did not have any shortness of breath but was often tired as she didn't sleep that well at night. R47 stated that when she was at the hospital, she had been using the CPAP and had also been using it before admittance to the facility and wanted to use one now. R47 stated she had not used a CPAP at the facility since she was admitted in 2021, as her machine had been misplaced. R47 stated that after she had gone to the hospital last fall, the facility was supposed to help her get set up with a new machine. R47 stated that someone had talked with her once about it and had never gotten back to her with more information.	F 695		

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F 695	Continued From page 30 During an observation and interview on 3/12/24 at 8:24 a.m., R47 was observed lying in bed with a NC applied with supplemental oxygen running at a rate of three LPM. R47 stated she had told an unknown aide a few days ago that she was short of breath, so they had increased her oxygen to three LPM, but they had forgotten to come back and turn it down. R47 stated she hadn't seen anyone look or change it since then. During an interview and observation on 3/12/24 at 12:08 p.m., registered nurse (RN)-H, the nurse manager for long-term care, stated that she had "never" observed R47 using a CPAP machine. RN-H stated that when someone was admitted to the facility with CPAP use, they would continue their home settings on admittance unless the provider decided new settings were needed. RN-H stated she was unsure why R47 had not been started on CPAP therapy or reassessed for its appropriateness. RN-H stated that R47 was supposed to have her oxygen administered at one LPM and if R47 had respiratory distress and increased oxygen was needed, the staff member should have reached out to the NP. RN-E stated that it was important that R47 was not receiving too much supplemental oxygen, so her blood gases were maintained within normal limits. RN-H stated that the nurses should have been checking R47's supplemental oxygen level at least every shift because occasionally R47 would ask aides to increase her oxygen and that was completed inappropriately. During observation and interview on 3/12/24 at 12:19 p.m., R47's supplemental oxygen was observed at three LPMs and confirmed by RN-H. RN-H stated that R47's supplemental oxygen	F 695		

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F 695	Continued From page 31 "never" should have been increased to three liters. RN-H stated that if R47's oxygen saturation was low leading to the increase that should have been recorded in the progress notes, the provider should have been notified, and they should have titrated the oxygen back down to one liter as able. RN-I, the floor nurse, stated that she was unaware that R47's supplemental oxygen was running at 3 LPM and R47 had not reported any respiratory symptoms to her nor did the previous shift. RN-I stated she was unsure how long it had been running at three LPM as she had not checked the level but agreed with RN-H stating it should not have been running at three LPM. RN-I was observed to measure R47's oxygen saturation with a result of 97 percent which RN-H stated was too high for R47 to require three LPM. RN-H then lowered the oxygen to two liters and stated she would return to recheck the oxygen and titrate the oxygen back down to one liter as able as should have been completed before now. During an interview on 3/12/24 at 12:32 p.m., the medical records clerk (MRC) stated that normally residents will come in already using a CPAP and she has never scheduled an appointment for new CPAP settings including R47. During an observation and interview on 3/13/24 at 7:03 a.m., R47's supplemental oxygen was observed at one LPM and R47 stated that she had not had any shortness of breath or other respiratory symptoms since her oxygen was decreased. During an interview on 3/13/24 at 12:41 p.m., the nurse practitioner (NP) stated that she had just put in an order to discontinue the CPAP therapy. The NP stated that R47 needed updated CPAP	F 695		

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F 695	Continued From page 32	F 695		

machine settings so a sleep apnea test needed to be completed before R47 could start using a CPAP again as the old settings were outdated. The NP stated that R47 had "morbid obesity hypoventilation" and the CPAP was an important intervention for her health.

During an interview on 3/13/24 at 12:58 a.m., the NP stated that it was important that R47's oxygen was administered as ordered and if an increase was needed, that staff notify her so she could further assess and determine the cause and appropriateness of the increased oxygen. The NP stated she was unaware that R47 was receiving oxygen at three LPMs as she did not recall notification of this. The NP stated that she would have been worried because of the COPD history, R47 would have an increase in her carbon dioxide levels leading to possible free radical damage if oxygen was administered inappropriately. The NP stated when R47 was receiving oxygen at three LPM, this could have led to a decrease in respirations and "essentially shutting down" R47's respiratory system.

During an interview on 3/14/24 at 1:03 p.m., licensed practical nurse (LPN)-A, the NP's care coordinator, stated that the resident had asked her about getting a new CPAP in 2/24. LPN-A stated that R47 had wanted more information regarding the testing required to get a new CPAP before making her decision on whether she wanted to move forward with this, and preferred testing done in the facility if possible. LPN-A stated she had not been able to follow up with R47 to give her any additional information as she only visited the facility once a month.

During an interview on 3/14/24 at 1:38 p.m., the

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F 695	Continued From page 33 director of nursing (DON) stated the facility had not been aware of R47's need for a CPAP machine. The DON stated that she expected the nurse manager and the admitting nurse to review hospital notes with facility admissions and readmissions to ensure R47 received the respiratory care she needed. The DON stated that she did not think that a CPAP had been offered to R47 because they were unaware of this need. The DON stated that if an appointment was scheduled it would have been completed by the MRC. The DON stated that R47 should not have been receiving supplemental oxygen above the rate ordered in the order summary without provider notification and increased monitoring. The DON stated that this increased oxygen use could have an adverse effect on R47's health. A policy regarding respiratory care was requested and not received.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		4/7/24

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F 732	Continued From page 34 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nurse staffing information was posted on the weekend and in a timely manner at the start of the shift. This had potential to affect all 69 residents, staff, and visitors who could wish to review this information. Findings include: During entrance to the nursing home, on Monday, 3/11/24 at 11:30 a.m., a clear plastic holder was observed attached to the wall to the left of the main reception desk. This contained a document titled, "Daily Staff Posting - Woodlyn Heights Health Care Center." However, the document displayed was dated, "3/7/202 [four days prior]."	F 732	F 732 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective	

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F 732	Continued From page 35 The form contained the actual and total hours of registered nurses, licensed practical nurses, trained medication aides, and certified nursing assistants which was broken down into each respective shift (i.e., day shift, evening shift, night shift). There was no visible nurse staffing information posted or displayed for Friday, 3/8/24, Saturday, 3/9/24, Sunday, 3/10/24, or Monday, 3/11/24. During interview on 3/11/24, at 11:35 a.m., administrative assistant (AA)-A, verified the posting was dated 3/7/24. They verified there were no other nurse staff information postings present. They indicated the staffing coordinator managed the staff posting. On 3/14/24 at 7:30 a.m., the staff posting posted was noted to be dated 3/12/24. On 3/14/24 at 10:31 a.m., staffing coordinator (SC)-A indicated they are responsible for creating the staff posting. They indicated they will typically post it when they arrive to work otherwise the charge nurse on night shift will post it. They indicated that "sometimes I get the dates mixed up". They indicated if the wrong date was posted it "might look like we have less staff" or "the census is wrong". On 3/14/24 at 11:17 a.m., director of nursing (DON) indicated it is important to have the correct staff posting posted. Further, DON stated the posting depicts the staffing in the building, and the intention was to give the right representation of staffing in the building. DON verified there was only one staff posting posted which is located to the left of the reception desk by the main entrance.	F 732	action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 732, Posted Nurse Staffing Information. Woodlyn Heights Senior Living corrected the deficiency by updating the posting with the correct date on 3/11/2024. 2. To correct the deficiency and to ensure the problem does not recur staffing coordinator and weekend charge nurses were educated on 4/5/2024 on the staff posting process and location by Executive Director The Executive Director and/or designee will audit the postings 4x a week for 4 weeks. 3. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community□s QA Process.	

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F 732	Continued From page 36 On 3/14/24 at 1:51 p.m., the administer was interviewed and indicated that the staff posting gives staff, residents, and families an account of how many residents are residing in the facility. Further, administrator stated it also shows how many residents the staff are responsible for. A facility policy for staff posting was requested but not received.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		4/7/24

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F 758	Continued From page 37 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed provide appropriate side effect monitoring with psychotropic medication consumption for 1 of 5 residents (R24) reviewed for unnecessary medication use. Findings include: R24's quarterly Minimum Data Set (MDS) dated 1/9/24, indicated R24 had severe cognitive impairment and was dependent on assistance with activities for daily living (ADLs). The MDS included diagnoses of hypertension (high blood pressure), epilepsy (seizure disorder) and renal insufficiency/renal failure/end-stage renal disease (kidneys no longer adequately filtering waste from	F 758	F (F758) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective	

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F 758	Continued From page 38 the blood). The MDS indicated R24 had hallucinations, delusions and no physical or verbal aggression. R24's physician note, dated 2/7/24, included the following diagnoses; personal history of traumatic brain injury (TBI), chronic kidney disease, major depressive disorder recurrent severe with psychotic symptoms, restlessness and agitation, unspecified fall, hypertensive heart disease without heart failure and generalized anxiety disorder. R24's Order Summary Report dated 3/14/24, identified R24 had physician orders for several medications including the following: -duloxetine HCL (medication to treat major depressive disorder) delayed release capsule: give 80 milligrams (mg) by mouth one time a day related to major depressive disorder, recurrent, severe with psychotic symptoms with a start date of 8/3/23 -Seroquel (medication to treat certain mental/mood disorders) 100 mg tablet: give 100 mg by mouth two times a day related to major depressive disorder, recurrent, sever with psychotic symptoms with a start date of 11/27/23 -trazodone HCL (medication to treat major depressive disorder) oral tablet: give 150 mg by mouth one a day for trouble sleeping with a start day of 8/3/23 R24's medication administration record (MAR) for March, printed 3/13/24, lacked evidence of monitoring of monthly orthostatic blood pressures, side effects of psychotropic	F 758	action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (758), Free from Unnecessary Psychotropic Meds/PRN Use. Woodlyn Heights Senior Living corrected the deficiency by adding orders for monthly orthostatic blood pressures, side effects of psychotropic medications, and non-pharmacological interventions for sleep or behaviors to MAR/TAR and care plan for R24 and all like residents on 4/3/24. 2. To correct the deficiency and to ensure the problem does not recur all licensed nursing staff were educated on Psychotropic Medication Monitoring on April 2nd and 3rd or prior to their next scheduled shift by DON. 3. The DON and/or designee will audit MAR/TAR of 5 residents with psychotropic medication use for side effect monitoring, monthly orthostatic blood pressures, sleep and behavior monitoring 3x a week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks, and then as needed to ensure continued compliance. 4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the	

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F 758	Continued From page 39 medications, non-pharmacological interventions for sleep or behaviors or indication of target behaviors. R24's care plan, dated 1/13/24, identified R24 has the potential for falls related to impaired balance, weakness, impaired cognition, organic brain dysfunction, history of TBI, fall history, psychotropic medication use, and incontinence. R24's care plan identified R24 is on antipsychotic medication. Interventions listed included: -"attempt non-pharmacological intervention and observe effectiveness" -"observe/record target behaviors/symptoms and document per facility protocol" -"psychoactive med: monitor for possible side effects (document abnormal findings in progress notes) decreased appetite, dry mouth, difficulty voiding, constipation, dizziness, unsteady jittery, restless, headache, stiff neck, tense muscles, stiff muscles, tremors, slow movement, dyspnea, shortness of break, blood pressure changes. " - "Observe/document/report to medical practitioner PRN signs/symptoms of psychotropic drug complications: altered mental status, decline in mood or behavior, hallucinations, delusions, social isolation, withdrawal, decline in ADLs & continence & cognition, suicidal ideations, constipation, impaction, urinary retention, shuffling gait, rigid muscles, syncope, accidents, dizziness, vertigo, Motor agitation, Tremors, tardive dyskinesia, poor balance, Diarrhea, fatigue, insomnia, loss of appetite, weight loss, N&V" - "Develop a behavior management program with alternatives to medication use." R24's care plan identified R24 was on an	F 758	community's QA Process.	

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F 758	Continued From page 40 antidepressant medication. Interventions listed included: - "Observe/document/report to medical practitioner prn [as needed] ongoing signs/symptoms of depression unaltered by antidepressant meds: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety" - "Monitor for possible side effects (Document abnormal findings in Progress Notes) Decreased Appetite, Dry Mouth, Difficulty Voiding, Constipation, Dizziness, Unsteady, Jittery, Restless, Headache, Stiff Neck, Tense Muscles, Stiff Muscles, Tremors, Slow Movements, Dyspnea, Shortness of Breath, BP Changes" - "Attempt non-pharmacological interventions and observe effectiveness." - "Report to Nurse prn ongoing signs/symptoms of depression: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance" R24's care plan lacked evidence of non-pharmacological interventions attempted in	F 758		

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F 758	Continued From page 41 the past or present and effectiveness. It also lacked non-pharmacological interventions for sleep. R24's progress notes, printed 3/14/24, reviewed for the last 90 days lacked evidence of monitoring for side effects of psychotropic medication or monitoring of sleep. R24's vital signs summary, printed 3/13/24, lacked evidence of orthostatic blood pressure monitoring in the last 6 months. The package insert for Seroquel dated 1997, indicated metabolic changes (increase in cholesterol, weight gain, increased risk of diabetes), seizures, hypothyroidism (thyroid gland does not produce enough thyroid hormone), potential for cognitive and motor impairment (partial or total loss of function of a body part), dysphagia (difficulty swallowing), falls, orthostatic hypotension (a drop in blood pressure while standing), dizziness, and syncope (fainting) could lead to falls. The insert also indicated Seroquel should be used with particular caution in patients with known cardiovascular disease such as heart failure. Seroquel's drug classification is an antipsychotic medication. The package insert for duloxetine dated 2004, indicated the following side effects: orthostatic hypotension, activation of mania/hypomania, increases in blood pressure, seizures. Duloxetine's classification is a serotonin and norepinephrine reuptake inhibitor (SNRI). The package insert for trazodone, reviewed 2024, indicated the following side effects: cardiac arrhythmia (heart rhythm that isn't normal),	F 758		

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F 758	Continued From page 42 activation of mania or hypomania, and orthostatic hypotension. Trazodone's drug classification is selective serotonin reuptake inhibitor (SSRI). The insert further indicates that using more than one SSRI or SNRI increases the risk for serotonin syndrome. Serotonin syndrome signs and symptoms may include mental status changes (e.g., agitation, hallucinations, delirium, and coma), autonomic instability (e.g., tachycardia, labile blood pressure, dizziness, diaphoresis, flushing, hyperthermia), neuromuscular symptoms (e.g., tremor, rigidity, myoclonus, hyperreflexia, incoordination), seizures, and gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). On 3/14/24, at 10:23 a.m., nurse manager (E) stated that monitoring of side effects of antipsychotic behaviors is done in the MAR. NM-E was not able to locate lab results since R24's admission for a lipid panel (blood test to check cholesterol levels). They stated "the doctor would have to order that if that was something they wanted." On 3/14/24 at 11:17 a.m., director of nursing (DON) stated it is important to monitor for side effects for psychotropic medications and must intervene. She indicated you want the person to be comfortable and want to eliminate the side effects if you can. She indicated that side effect monitoring for anti-psychotic and anti-depressant medications is found on the MAR. She indicated it is important to monitor orthostatic blood pressures with any psychotropic medications. DON verified that R24 does not have side effect monitoring in place the anti-psychotic or anti-depressant medication R24 is receiving. DON verified R24 has not been getting orthostatic	F 758		

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	245320	A. BUILDING _____ B. WING _____	C 03/14/2024

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F 758	Continued From page 43 blood pressures completed. DON verified R24 sleep is not being monitored on the MAR. DON verified that there are currently no non-pharmacological interventions in place on the MAR for R24. On 3/14/23 at 1:51 p.m., administrator stated it is important to be monitoring for side effects of psychotropic medications. The monitoring is done on the MAR in the EMR. A facility policy PRN Psychotropic Medication Process dated 11/7/22, was provided. The policy indicated non-pharmacological approaches and techniques must be implements. The policy lacked information of monitoring for side effects/effectiveness of psychotropic medication.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 residents (R27) reviewed for medication errors were free of significant medication errors whenwhen R27 didn't receive ordered metoprolol (medication to treat high blood pressure and control heart rate) for 30 days and in addition, R27 didn't receive ordered atorvastatin (medication to treat high blood cholesterol) between 2/13/24 and 3/13/24. Findings include: R27's quarterly Minimum Data Set (MDS) dated	F 760	F (F760) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for	4/7/24

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F 760	Continued From page 44 1/23/24, indicated R27 was cognitively intact and had no issues with mood or behavior. MDS indicated R27 needed assistance to set up her meals, supervision with showers, and was independent with dressing, toileting, bathing, and transfers. R27's Medical Diagnosis report printed 3/13/24, indicated diagnoses of multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), unspecified psychosis (a mental disorder characterized by a disconnection from reality), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body), generalized anxiety, idiopathic chronic gout (a condition caused by too much uric acid in the body which causes swelling and pain around the affected joint), chronic pain, type II diabetes (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), hypertension (high blood pressure), major depression, and personality disorder. R27's facility's Medical Orders printed on 3/13/24, did not include orders for metoprolol (a medication prescribed to treat hypertension) or atorvastatin (a medication prescribed to treat high cholesterol). R27's clinic Medication Reconciliation report dated 2/13/24 indicated to take metoprolol tartrate 50 milligrams (mg) by mouth twice a day for hypertension. Orders also indicated R27 take half a tablet of atorvastatin calcium 80 mg tablet by mouth every day.	F 760	procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (760), Residents are Free of Significant Medication Errors. Woodlyn Heights Senior Living corrected the deficiency by reconciling R27 medication with the list of medication provided by clinic on 3/14/24. R27 has since been discharged from the facility. All residents with medical appointments in last 30 days were reviewed for completion of medication reconciliation from last clinic visit on 4/3/24. 2. To correct the deficiency and to ensure the problem does not recur all licensed nursing staff were educated on Transcribing and Reconciling Physician Orders on April 2nd and 3rd or prior to their next scheduled shift by DON. 3. The DON and/or designee will audit all resident with outside medical appointments for completion of medication reconciliation upon return from appointment 3x a week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks, and then as needed to ensure continued compliance. 4. As part of Woodlyn Heights Senior	

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F 760	Continued From page 45 R27's medical record lacked documentation concerning the clinic's Medication Reconciliation report, received on 2/13/24, was reviewed by the nursing staff. Review of R27's facility medical record did not indentify orders for metoprolol and atorvastatin following the clinic visit. R27's Medication Administration Record for the months of February and March 2024 lacked documentation for or administration of metoprolol and/or atorvastatin. R27 was not documented as having been administered either medication between 2/13/24 and 3/13/24. During interview on 3/13/24 at 1:10 p.m., nurse manager/register nurse (RN)- H verified the orders for metoprolol and atorvastatin were not included in facility's physician orders and verified R27 had not received either medication between 2/13/24 and 3/13/24. During interview on 3/13/24 at 2:04 p.m. director of nursing (DON) stated she expected the nurses to check medication orders received from a provider the same day and compared them to the R27's facility's physician orders. DON stated the nurse on duty should have contacted the provider if the medication orders didn't match. DON stated the medication list needed to be reconciled following a provider clinic visit to assure the facility had the correct orders and to prevent negative outcomes for the resident. A facility policy on medication management was requested and but not provided.	F 760	Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5)	F 791		4/7/24

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F 791	Continued From page 46 §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are	F 791		

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F 791	Continued From page 47 eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental needs were appropriately acted upon for 1 of 1 residents (R47) reviewed for dental care. Findings include: R47's quarterly Minimum Data Set (MDS) dated 2/27/24, indicated R47 had intact cognition with no behaviors present. The MDS indicated R47 was diagnosed with heart failure, diabetes, and depression and required setup assistance with oral hygiene. R47's dental progress note dated 1/4/24, indicated that the doctor of dental surgery (DDS) recommended that R47 have five teeth extracted prior to moving forward with a partial denture. R47's dental General Referral dated 1/4/24, indicated that the DDS recommended R47 to see an oral surgeon for extraction of five teeth related to fractured teeth/ root tips that were not restorable. The note also indicated that these teeth were causing R47 pain. R47's progress note dated 2/27/24 at 5:33 p.m., indicated that R47 had "obvious or likely cavity or broken natural teeth". R47's care plan dated 12/16/23, indicated R47 was independent after set up help for oral care. During an interview and observation on 3/11/24 at	F 791	F (F791) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (791), Routine/Emergency Dental Services in NFs. Woodlyn Heights Senior Living corrected the deficiency by contacting R47 dental provider to arrange for tooth extraction per dentist recommendations on 4/4/2024. All residents seen by dentist during last in-house visit (1/4/2024) were reviewed to ensure dental needs were acted upon on 4/3/24.	

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F 791	Continued From page 48 12:41 p.m., R47 was observed lying on her back in bed with two missing front bottom teeth. R47 stated that she was "supposedly" going to see an oral surgeon to have teeth pulled and then "hopefully" she would get dentures made for her missing bottom teeth. R47 stated no one had followed up with her regarding this potential appointment. R47 stated that she had mouth pain related to the missing teeth and cavities so she had to avoid these areas while eating, which bothered her. During an interview on 3/12/24 at 12:08 p.m., nurse manager (NM)-E stated that R47 saw the dentist every six months and it looked like R47 was recommended to get five teeth extracted after her last visit in 1/24. NM-E stated that the medical records clerk (MRC) oversaw taking these referrals and setting up the related appointments and she was unsure if this had been completed. During an interview on 3/12/24 at 12:28 p.m., the MRC stated that she oversaw setting up dental and other out-of-facility appointments for the residents in the facility. The MRC stated that this was the first time she was seeing the dental referral for R47 and therefore an appointment with the oral surgeon had not been scheduled. During an interview on 3/14/24 at 1:39 p.m., the director of nursing (DON) stated that the MRC oversaw setting up out-of-facility resident appointments and it was important that these appointments were scheduled. A policy regarding dental needs was requested and not received.	F 791	2. To correct the deficiency and to ensure the problem does not recur Medical Records Designee was educated on Dental Services in a NFs and ensuring appropriate follow up with all dental recommendation on 4/4/24 by DON. 3. The DON and/or designee will audit all dental visit notes and recommendations for appropriate follow up 3x a week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks, and then as needed to ensure continued compliance. 4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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F 842	Continued From page 49	F 842		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		4/7/24

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F 842	Continued From page 50 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain accurate medical records to ensure accurate medication lists, nurse/licensed professional monitoring and interventions were implemented for 2 of 2 residents (R2 and R27) reviewed. DOUBLE CHECK THIS Findings include,	F 842	F (F842) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	

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F 842	Continued From page 51 R27's quarterly Minimum Data Set (MDS) dated 1/23/24 indicated R27 was cognitively intact and had no issues with mood or behavior. MDS indicated R27 needed assistance to set up her meals, supervision with showers, and was independent with dressing, toileting, bathing, and transfers. R27's Medical Diagnosis report printed 3/13/24 indicated diagnoses of multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), unspecified psychosis (a mental disorder characterized by a disconnection from reality), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body), generalized anxiety, idiopathic chronic gout (a condition caused by too much uric acid in the body which causes swelling and pain around the affected joint), chronic pain, type II diabetes (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), hypertension (high blood pressure), major depression, and personality disorder. During R27's record review on 3/12/24, several discrepancies were noted between a list titled "current med list" dated 2/13/24 from R27's clinic provider and the facility's Medical Orders. R27's Facility's orders did not include the following orders which were listed on the clinic provider medication list: Atorvastatin calcium (treats high cholesterol levels) 80 milligrams (mg) tablet, take one-half every day for cholesterol.	F 842	corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (842), Residents Records-Identifiable Information. Woodlyn Heights Senior Living corrected the deficiency by adding order for intrathecal baclofen pump dose, rate, refill, placement, assessment, monitoring, and management to R2's MAR by 4/3/24 by DON. R27's clinical provider and facility's medical orders were reconciled, and discrepancies were corrected on 3/13/24 by nurse manager. R27 has since been discharged from the facility. All residents with medical appointments in last 30 days were reviewed for completion of medication reconciliation from last clinic visit on 4/3/24. 2. To correct the deficiency and to ensure the problem does not recur 1:1 education provided to nurse manager on ensuring accurate medication list and implementation of monitoring and interventions when indicated by DON on 4/4/24.	

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F 842	Continued From page 52 Diclofenac (used to treat mild to moderate pain) NA 1% topical, apply 2 grams topically three times a day as needed for shoulder pain **Use dose card in box to measure dose. Lidocaine (anesthetic cream used to treat pain) 4% topical cream, apply a moderate amount to right foot at bedtime for pain. Metoprolol tartrate (treats high blood pressure) 50 mg, take one tablet twice a day for hypertension. R27's facility's orders didn't match the clinic orders for Melatonin (sleeping aid) 3 mg cap/tab. Take 2 tablets (6 mg) by mouth at bedtime for sleep. The facility's orders indicated to administer 3 tablets (9 mg). During interview on 3/13/24 at 1:10 p.m. nurse manager/registered nurse (RN)-H verified the discrepancies between the facility's medication orders and the clinic's "current medication list". RN-H was unable to provide documentation when the atorvastatin, metoprolol, lidocaine and/or diclofenac orders were discontinued. RN-H stated R27 went to her clinic on 2/13/24 R27. On 2/13/24 at 3:45 p.m. the clinic sent a fax containing the alleged current medication list. RN-H stated the nurse on duty did not reconcile the medication orders as expected. During interview on 3/13/24 at 1:50 p.m. the medical director stated, the facility's medication list often doesn't match the clinic records. Medical director stated it would be concerning if the lists didn't match. The nurse manager should ask the provider to review the medications and reconcile the orders. During interview on 3/13/24 at 2:04 p.m. director	F 842	3. The DON and/or designee will audit all resident with outside medical appointments for completion of medication reconciliation with clinic medication list upon return from appointment 3x a week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks, and then as needed to ensure continued compliance. The DON and/or designee will audit MAR/TARs and Care Plan of all residents with baclofen pump for appropriate assessments, monitoring, and management of pump 3x a week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks, and then as needed to ensure continued compliance. 4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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F 842	Continued From page 53 of nursing (DON) stated she expected the nurses checked any orders or current medication list received from a provider on the same day and compare them to the facility's physician orders. DON stated the nurse on duty should have contacted the providers if the medication orders didn't match. The medications needed to be re-conciliated to assure the facility had the correct orders and to prevent negative outcomes for the resident. R2 R2's Order Summary Report, printed 3/14/24, included the following diagnoses: presence of other specified devices. The report lacked evidence of an order for the intrathecal baclofen pump [surgically implanted pump that delivers medication directly to the fluid surrounding the spinal cord] which indicated the placement, dose, and rate of medication R2 received daily. The report lacked evidence of the last fill of the pump or when it is due to be filled. R2'S quarterly MDS, dated 12/12/23, identified R2 had intact cognition. Diagnoses included: progressive neurological conditions, multiple sclerosis (autoimmune disorder which damage the insulating covers of the nerve cells in the brain and spinal cord), anemia (low red blood cells), neurogenic bladder (lack of bladder control due to nerve problems), malnutrition, pressure ulcer of unspecified part of back-stage 3, pressure ulcer of right lower back-stage 2. MDS lacked identification in the diagnosis of presence of other specified device. Section O: special treatment and program of the MDS was marked under Z1, indicated resident had "none of the above".	F 842		

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	245320	A. BUILDING _____ B. WING _____	C 03/14/2024

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F 842	Continued From page 54 R2's medication administration record for March 2024, printed 3/13/24, indicated the following orders: -[R2] may develop the following withdrawal symptoms when the battery for the internal intrathecal baclofen pump runs down or not working: baseline muscle spasticity, itching without a rash, twitching, low blood pressure, abnormal sensations, and/or other life threatening signs like high fever, confusion, rebound spasticity, or muscle rigidity. Administer oral baclofen (medication used to treat muscle spasms) PRN (as needed) as ordered. Notify the provider and contact the clinic of neurology [name of provide and number included] as needed for baclofen pump with a start date of 5/1/22 - baclofen tablet (medication for muscle spasms) 10 milligrams (mg) give 1 tablet by mouth every 4 hours as needed for baclofen withdrawal. R2 may develop the following withdrawal symptoms when the battery for the internal intrathecal baclofen pump runs down or not working: baseline muscle spasticity, itching without a rash, twitching, low blood pressure, abnormal sensations with a start date of 5/5/22. The medication administration record lacked evidence of monitoring or assessment of the intrathecal baclofen pump. R2's care plan, printed 3/14/23, had a sentence indicating "intrathecal baclofen pump: simple continuous to deliver 27.65 micrograms (mcg)/day". Care plan lacked any indication of how to monitor, placement of the pump, or management of pump. Review of R2's progress notes, dated from 9/13/23 to 3/12/24, lacked monitoring of	F 842		

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F 842	Continued From page 55 intrathecal baclofen pump. The notes lacked evidence of coordination with agency who fills the baclofen pump or note of the last fill. During observation and interview on 3/11/24, at 12:21 p.m., R2 was observed lying in bed. R2 stated she has a baclofen pump that manages the pain from the muscle spasms from the multiple sclerosis. R2 indicated that it was implanted in her abdomen and had it since before moving to the facility. R2 further indicated that staff do not monitor or look at the pump. R2 stated she thinks the pump was filled in December. On 3/13/24 at 11:14 a.m., registered nurse (RN)-F verified that they were currently working with with R2 and frequently worked with R2. Rn-F verified there are no orders in the electronic medical record (EMR) that indicate what dose of baclofen R2 gets from the intrathecal baclofen pump. RN-F verified that this would be important to know as they administer medications as there could be a reaction and for coordination of care when the resident goes to the hospital. RN-F verified they do not know the current dose of baclofen R2 gets and if the resident was transferred to another facility, this information would be missing. On 3/13/24 at 11:29 a.m., nurse manager (NM)-E indicated that they are familiar with R2. NM-E verified that there are no current orders for the baclofen pump listed on current medication list with current dose. They stated they monitor for withdrawal, would administer PRN baclofen, and notify the provider. NM-E indicated they should be monitoring the baclofen pump site. NM-E verified the nurses "really don't do anything with the	F 842		

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F 842	Continued From page 56 pump" and it should be monitored and assessed. NM-E stated the company who fills the pump came on a Sunday evening to fill the pump in December. NM-E indicated they were unsure if this was documented. NM-E verified that if the baclofen dose is not listed on the orders, another facility would not know what the current rate is if the resident was transferred. On 3/13/24 at 2:31 p.m., NM-E provided documentation of baclofen pump fill from Medtronic. The report indicated the baclofen pump was refilled on 7/18/23 and the setting currently set at baclofen 27.65 mcg/day. The report indicated the next fill was currently scheduled for 1/9/24. On 3/18/24, a copy of Medtronic report from the baclofen fill was provided. The report indicated R2's baclofen pump was filled on 1/9/24 at a current rate of 27.65 mcg/day with the next fill date of 6/25/24. On 3/14/24 at 11:17 a.m., director of nursing (DON) indicated that it is important that staff is aware of R2 intrathecal baclofen pump and the dose of baclofen R2 is receiving. DON verified the pump needs to be monitored and there is currently no monitoring in place. DON verified there is no dose listed on the current orders for the baclofen pump. A facility policy on medication management was requested and not provided. A facility policy on accuracy of records was requested but not provided.	F 842		
F 847 SS=D	Entering into Binding Arbitration Agreements	F 847		4/7/24

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F 847	Continued From page 57 CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care	F 847		

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F 847	Continued From page 58 at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure binding arbitration agreements were clearly communicated in a form and manner that they understood prior to signing the forms for of 2 of 2 residents (R2, R47) reviewed for binding arbitration agreements. Findings include: R2's quarterly Minimum Data Set (MDS) dated 12/12/23, indicated R2 had intact cognition and diagnoses of multiple sclerosis (A disease that affects central nervous system creating difficulty with sending brain signals to the rest of the body [MS]). Review of R2's signed Arbitration Agreement dated 2/3/22 indicated, "Resident and Facility will not be able to bring or start a lawsuit in any court and are giving-up all rights to a jury trial to decide any disputes that Resident may have against Facility or Facility may have against Resident." During interview with R2 on 3/14/23 at 8:45 a.m., R2 was unable to recall signing admission paperwork informing her that she was not	F 847	F 847 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 847, Entering into Binding Arbitration Agreements. Woodlyn Heights Senior Living corrected the deficiency by	

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F 847	Continued From page 59 required to enter into the binding arbitration agreement as a condition of admission. R2 stated, "I am sure I did sign a lot of paperwork [when admitted to facility]. I can do it. I am my own person [competent]. I do not recall anything about the arbitration agreement and giving up my right to go to court." R47's quarterly MDS dated 2/27/24 indicated R47 had intact cognition and diagnoses of heart failure, diabetes, and depression. Review if R47's signed Arbitration Agreement 10/25/21 indicated, "Resident and Facility will not be able to bring or start a lawsuit in any court and are giving-up all rights to a jury trial to decide any Disputes that Resident may have against Facility or Facility may have against Resident." Additional review of the agreement did not include evidence the binding arbitration agreement was explained in a form, manner and language that the resident or his or her representative understood. During interview with R47 on 3/14/24 at 9:34 a.m., R47 was unable to recall signing admission paperwork informing her that she was not required to enter into the binding arbitration agreement as a condition of admission. R47 stated, "I don't recall them [facility] explaining it [arbitration agreement] to me." And "no one explained it in a way I understood." During interview with social worker (SW) on 3/14/24 at 10:12 a.m., SW stated the arbitration agreement is included into the forty six page admission packet provided and reviewed by SW with resident and family or guardian at all facility admissions. SW stated the admission packet is provided by "corporate" and she had no input or	F 847	ensuring that the existing residents (R1, R2, R4, R5, R15, R17, R22, R28, R42, R47, and R48) and their representatives understand and either sign or decline the updated arbitration agreements by 4/5/2024. 2. To prevent this issue from recurring, the Executive Director, Social Services, and Business Office Manager were educated on the Arbitration Agreement policy on 3/29/2024 by the Executive Director. The Executive Director or designated personnel will audit new incoming admissions arbitration agreements weekly for 4 weeks, then 3 admissions a week for 4 weeks. 3. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community s QA Process.	

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F 847	Continued From page 60 training in what the arbitration agreement includes. SW stated, "we go over each page [with the resident or guardian]". Additionally, SW stated her process to determine competency includes decision about, "if they seem a little off or based on [their] diagnosis". SW stated, "I don't have anything to do with the legal aspect of the document when it come to it." During interview with administrator on 3/14/24 at 10:47 a.m., administrator stated, "[the] arbitration paperwork comes from our corporate office." And, "I don't play a great deal in [arbitration] but ensure that it is in admission paperwork and discussed in admission." Facility policy titled Voluntary Binding Arbitration Agreement Policy updated 10/25/2022 state, "Obtain the resident or his/her representative's acknowledgement the Voluntary Binding Arbitration Agreement (VBAA) was explained in a manner and form they understand, and that he/she/they understand the VBAA."	F 847		
F 848 SS=E	Binding Arbitration Agreements CFR(s): 483.70(n)(2)(iii)(iv)(6) §483.70(n)(2) The facility must ensure that: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties. §483.70(n)((6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that	F 848		4/7/24

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F 848	Continued From page 61 dispute on and be available for inspection upon request by CMS or its designee. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer a neutral and fair arbitration process by ensuring both the resident or his or her representative, and the facility agree on the selection of a neutral arbitrator, and that the venue is convenient to both parties for 11 of 17 residents (R1, R2, R4, R5, R15, R17, R22, R28, R42, R47, and R48) reviewed for binding arbitration. Findings include: Review of document titled Residents with Arbitration Agreements provided by facility on 3/11/24, documented R1, R2, R4, R5, R15, R17, R22, R28, R42, R47, and R48 with signed binding arbitration agreements with the facility. Review of R1, R2, R4, R5, R15, R17, R22, R28, R42, R47, and R48 Arbitration Agreements indicated, "The arbitration shall be administered by the American Health Lawyers Association (AHLA) in accordance with its Rules of Procedure". In addition, "The Arbitration will be conducted at a site selected by Facility". R47's quarterly MDS dated 2/27/24, indicated R47 had intact cognition and diagnoses of heart failure, diabetes, and depression. During interview with R47 on 3/14/24 at 9:34 a.m., R47 stated she did not understand that she was giving up her right to litigation in a court proceeding when she signed the arbitration agreement or that the arbitrator and location of	F 848	F 848 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 848, Binding Arbitration Agreements. Woodlyn Heights Senior Living corrected the deficiency by ensuring that the existing residents (R1, R2, R4, R5, R15, R17, R22, R28, R42, R47, and R48) and their representatives understand and either sign or decline the updated arbitration agreements by 4/5/2024. The arbitration agreement was updated to include a neutral and fair arbitration process with a neutral arbitrator and location per the federal regulations.	

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F 848	Continued From page 62 arbitration were decided by the facility. "No, I did not know." During interview with social worker (SW) on 3/14/24 at 10:12 a.m., SW stated the arbitration agreement is included in a forty six page admission packet provided and reviewed by SW with residents and family/guardian at all facility admissions. SW stated the admission packet is provided by "corporate" and she had no input or training in what the arbitration agreement included. SW stated, "we go over each page [with the resident or guardian]". During review of R17's signed arbitration agreement SW stated, "it is important to have a neutral arbitrator to mediate so you are not taking sides" and "[the site of arbitration] should be agreed upon site [sic] you don't want either party to feel pressured or [have] ill feelings due to the setting [location][which] recause [sic] trauma". Also, SW stated, "I don't have anything to do with the legal aspect of the document when it comes to it." During interview with business office manager (BOM) on 3/14/24 at 10:31 a.m., BOM stated "corporate" is responsible for any changes or updates to the admission packet. During review of R17's signed arbitration agreement BOM stated the arbitration agreement failed to include a neutral arbitrator or neutral site. BOM stated, "it is important to have neutral arbitrator that does not know either side [sic] will be more understanding [of] the dispute." BOM stated the facility chosen arbitrator, "will side with the facility" and not be neutral. BOM also stated the importance of a neutral site due to, "coming back into the facility might muster up more feelings of stress for the family or resident".	F 848	2. To prevent this issue from recurring, the Executive Director, Social Services, and Business Office Manager were educated on the Arbitration Agreement policy on 3/29/2024 by the Executive Director. The Executive Director or designated personnel will audit new incoming admissions' arbitration agreements weekly for 4 weeks, then 3 admissions a week for 4 weeks. 3. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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F 848	Continued From page 63 During interview with administrator on 3/14/24 at 10:47 a.m., administrator stated, "[the] arbitration paperwork comes from our corporate office." And, "I don't play a great deal in [arbitration] but ensure that it is in the admission paperwork and discussed during admission." The administrator stated, "[it is] important that both parties [resident/family and facility] can mutually select an arbitrator to work both sides like the ombudsman. Then every one feels like they are treated fairly and without bias." During review of R17's signed binding agreement, administrator stated, "the arbitrator the facility is choosing and [sic] controlling the procedure and in control" and "location on this form means it will be determined [by the facility]." Facility policy titled Voluntary Binding Arbitration Agreement Policy updated 10/25/2022 directed facility to "Provide for the selection of a neutral arbitrator, agreed upon by both parties, and a venue convenient for both parties."	F 848		
F 880 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 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:	F 880		4/7/24

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F 880	Continued From page 64 §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 §483.70(e) 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 involved in direct resident contact.	F 880		

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(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
F 880	Continued From page 65 §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 record review, the facility failed to ensure community use glucometers were properly cleaned and disinfected between patient use for 4 of 4 residents (R10, R47, R42, R35) to have their blood glucose checked with the devices. This had the potential to affect 25 of 69 identified in the facility with orders to obtain blood glucose monitoring. In addition, the facility failed to ensure a wound vac machine was kept off the floor for 1 of 1 residents (R176) reviewed for wound care. Glucometer disinfecting between residents Per manufacturer's instruction for use of Even Care G3 Blood Glucose Monitoring System in the Cleaning and Disinfecting section highlighted the EVENCARE G3 Meter should be cleaned and disinfected between each patient and to avoid wetting the meter test strip port. The document further indicated, the approved and recommended Environmental Protection Agency (EPA) direction included using Medline Micro-Kill+ (Trademark) Disinfecting wipes.	F 880	F (F880) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F(880), Infection Prevention & Control. Woodlyn Heights Senior Living corrected	

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	245320	A. BUILDING _____ B. WING _____	C 03/14/2024

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F 880	Continued From page 66 According to Medline manufacturer guidelines, Medline Micro-Kill+ has a one-minute contact time, meaning the surface must remain wet with the product to achieve disinfection. During observation on 3/13/24, at 7:28 a.m., medication administration was observed with registered nurse (RN)-D present. RN-D prepared R10's oral medications. When finished, RN-D picked up the plastic caddy that contained an Even Care G3 glucometer along with R10's prepared oral medications and entered R10's room. Inside the room, RN-D removed an Even Care G3 glucometer from it. RN-D donned a pair of gloves and inserted a new strip into the device to test R10's blood glucose. RN-D then used a lancet to pierce R10's finger exposing a visible blood flash. RN-D touched the exposed blood droplet to the strip which had been inserted into the glucometer. A reading was obtained with RN-D stating aloud, "115." RN-D removed the strip from the glucometer and disposed of it in the trash. RN-D then placed the glucometer back into the plastic caddy without any attempt to clean or sanitize the device. RN-D returned to the medication cart with the caddy and placed it on top of the cart. RN-D prepared and administered R10's insulin, and then again returned to the cart to complete documentation. There was no attempt to remove or clean the used glucometer. The caddy did not contain any disinfectant wipes. During observation on 3/13/24, at 8:14 a.m., RN-D was observed to carry the caddy into R47's room and return to the medication cart and write down the blood glucose. There was no attempt observed to remove or clean the used glucometer. At 8:18 a.m., RN-D entered R42's room carrying the caddy to obtain a blood	F 880	the deficiency by providing education to RN-D and RN-F on glucometer disinfection for R 10, R 47, R42, R35 and all like resident by the DON on 4/5/2024. R176 wound vac was picked up off the floor and disinfected per manufacturer recommendations on 3/11/24. All residents with wound vacs reviewed to ensure wound vac was in black carrying case and placed away from the floor on 3/11/24. 3. To correct the deficiency and to ensure the problem does not recur all licensed nurses and TMAs had competency training on Glucometers Disinfection and Infection Control related to wound vacs on April 2nd and 3rd or prior to their next scheduled shift by DON. 3. The DON and/or designee will audit 5 blood glucose checks to ensure proper disinfecting procedure is being followed 3x a week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks, and then as needed to ensure continued compliance. The DON and/or designee will audit all wound vacs to ensure vacs placed in carrying case and away from the floor 3x a week for 4 weeks, then 2x a week for 4 weeks, weekly x 4 weeks, and then as needed to ensure continued compliance. 4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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	245320	A. BUILDING _____ B. WING _____	C 03/14/2024

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F 880	Continued From page 67 glucose. RN-D exited the room at 8:20 a.m., and unidentified staff approached them stating that a resident was waiting for their blood sugar to be checked. RN-D went directly into R35's room, carrying the same caddy. During interview on 3/13/24 at 8:25 a.m., RN-D verified that it is important to disinfect all communal resident equipment to stop the transmission of viruses. They verified that they had disinfected the glucometer at the beginning of the shift. They verified they had checked blood glucose levels for residents listed above and did not disinfect the glucometer between uses. They stated, "I should have done that.". They indicated they should be using the sani-wipes in-between uses. RN-D indicated they should use the Medline Micro-Kill+ disinfectant wipes. According to an order listing report, printed 3/14/24, the residents listed have the following orders for blood glucose (BG) monitoring: -R10: blood glucose monitoring: obtain blood sugar via meter and record result one time a day for DM [diabetes mellitus] -R35: blood glucose monitoring: obtain blood sugar via meter and record results before meals and at bedtime notify provider if two BG results are ,70 or <400 in a 24-hour timeframe and/or change in condition; if no condition change, notify provider on the next business day -R42: blood glucose monitoring: obtain blood sugar via meter and record results before meals and at bedtime related to type 2 diabetes mellitus with hyperglycemia	F 880		

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F 880	Continued From page 68 -R47: blood glucose monitoring; obtain blood sugar via meter and record results prior to breakfast and supper two times a day for DM type 2. During medication observation, the community use glucometer was observed to be wrapped in a dried cloth in a plastic caddy on the top of the medication cart. During interview on 3/13/23 at 8:49 a.m., RN-F stated that they wipe down the community use glucometer between each resident use. RN-F stated they then wrap it in a sani-cloth to "help clean it more" and place the glucometer that is wrapped in a wet sani-cloth back into the caddy. RN-F stated they were trained to clean the glucometer this way. RN-F stated it is not always dry between uses and further indicated that "it was wrapped with a wipe, so it is clean." RN-F indicated they use the Medline micro-kill disinfectant wipes. During interview on 3/14/24 at 11:17 a.m., director of nursing (DON) indicated any community use device needs to be cleaned after each resident use as this helps stop the spread of infections. DON indicated they must follow the manufacturer guidelines. DON stated that the facility recently had their skills fair and this was covered at the skills fair. DON indicated it is the expectation that equipment is cleaned between resident uses by following manufacturer guidelines. During interview on 3/14/24 at 1:51 p.m., administrator stated infection control is very important. He indicated it is important to ensure all communal use equipment is cleaned between resident use.	F 880		

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F 880	Continued From page 69 A facility policy titled "general information prevention and control- nursing standard", dated 10/5/23, blood glucose meters can become contaminated with blood and, if used for multiple residents, must be cleaned, and disinfected after each use according to manufacturer's instructions for multi-resident use. R176 R176's admission Minimum Data Set (MDS) dated 3/3/24, indicated R176 was cognitively intact, had no behaviors, did not refuse cares, and needed moderate assistance with transfers, turning and repositioning. MDS also indicated R176 was independent with oral care, eating and personal hygiene. R176 needed substantial assistance for toileting, bathing, and lower body dressing. R176's MDS indicated diagnoses of stage 4 pressure ulcer on the left buttock (sores extend below the subcutaneous fat into muscles, tendons and/or bones), hypertension (high blood pressure), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), neurogenic bladder (lack of bladder control due to spine or nerve injuries), and neuralgia (pain caused by damaged or irritated nerves). R176's physician orders printed 3/11/24, included orders to clean wound with wound cleanser, and standard wound vac (vacuum-assisted closure is a method of decreased air pressure around a wound to assist the healing). R176's treatment administration record (TAR) printed 3/12/24, indicated wound/dressing every	F 880		

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F 880	Continued From page 70 Tuesday, Thursday, and Sunday. During observation on 3/11/24 at 2:44 p.m., R176's wound vac machine was observed on the floor next to R176's bed. The wound vac was turned on and was connected by a drainage tube to R176's left buttock's wound dressing. During interview on 3/11/24 at 4:29 p.m., registered nurse (RN)-A verified the wound vac machine was on the floor. RN-A stated the floor is dirty and bacteria could travel up to her wound. A wound vac should not be on the floor, this an infection control issue". During interview on 3/14/24 at 9:10 a.m., nurse manager/registered nurse (RN)-G stated the wound vac machine should be kept in the bag provided by manufacturers and should hang on the bed, away from the floor. RN-G added placing a wound vac on the floor was an infection control concern. During interview on 3/145/24 at 9:22 a.m., infection preventionist/director of nursing (DON) stated all wound vacs had a bag in which to be carried or hung away from the floor. DON stated, "the machine [wound vac] should never touch the floor because the floor is full of germs and represented a risk for infection for an already compromised patient [R176]." Facility's policy titled Surveillance and Monitoring dated 10/5/23 indicated "It is the protocol of this facility that routine surveillance and monitoring of the workplace be conducted to determine if compliance with work practices and care of protective clothing and equipment is maintained".	F 880		

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	245511	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2024**

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CENTRACARE HEALTH MONTICELLO	**1013 HART BOULEVARD** **MONTICELLO, MN 55362**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/27/2024. At the time of this survey, Centracare Health- Monticello 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/20/2024

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 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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR 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. The facility is a 2-story building with a Sub-basement built in 1986 and was determined to be of Type II(222) construction. The facility is fully fire sprinkler protected and has a fire alarm system with smoke detection in corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 67 beds and had a census of 47 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 225 SS=D	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell arrangement and markings per NFPA 101 (2012 edition), Life Safety Code, section 7.7.3.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/27/2024 between 9:00am and 12:00pm, it was revealed by observation that emergency exit egress gate in the sub floor basement stairwell did not fully close due to the use of a hold-open device. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 225	Egress gate leading to sub-basement was immediately closed and signage placed to instruct those passing through this stairway to keep gate closed. No other stairwells in care center continue more than one-half story beyond the level of discharge. Signage placed at this egress gate to communicate expectation to keep gate closed. Facility staff will be educated regarding 7.7.3.4 life safety code and the need to keep this gate closed. Administrator, or designee, will complete audit of egress gate closure weekly for four weeks, then monthly for three months, and then as determined by the Quality Assurance Committee.	4/9/24

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K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/27/2024 between 9:00am and 12:00pm, it was revealed by observation that the exterior lights for door outside door marked 10503 had only one bulb for illumination. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 281	Exterior lighting for outside door marked 10503 was replaced to meet compliance with Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. on 3/11/2024. Facility exterior bulb illumination outside of Care Center doors will be audited to determine compliance with Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. All areas of concern will be corrected with bulb illumination to be in compliance with Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. Facility will be in compliance post installation of new lighting. Care Center Administrator or designee, is responsible for corrective actions and monitoring of compliance.	4/9/24
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall	K 372		4/9/24

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K 372	Continued From page 4 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 REQUIREMENT 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 02/27/2024 between 9:00am and 12:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors located at 1) above door second floor - North 2) above second floor - East On 02/27/2024 between 9:00am and 12:00pm, it was revealed by observation that there was a penetration in the following rooms 1) Penetration in Electrical Room - A132 2) Penetration in Electrical Room - 1076 3) Penetration in TR Room An interview with the Director of Maintenance verified these deficient findings at the time of	K 372	Penetrations identified in the following locations at time of survey have been filled/corrected on 2/27/2024: 1. Above door second floor – North 2. Above second floor – East 3. Electrical room A132 4. Electrical room 1076 5. TR room Communication will occur with vendors, who may complete work above facility ceiling, prior to work being completed regarding expectation to fill penetrations that may occur during work. Facility to audit, post work above facility ceiling, to ensure there are no penetrations post work. Facility to add an audit of looking for above ceiling penetrations to monthly preventative maintenance program. Administrator, or designee, will audit added preventative maintenance completion pertaining to penetrations for four months and thereafter as determined	

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(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
K 372	Continued From page 5 discovery.	K 372	by the Quality Assurance Committee.	
K 761 SS=E	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 REQUIREMENT 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 02/27/2024 between 9:00am and 12:00pm, it was revealed by observation that the fire doors leading from the first and second floor dinning room were missing door rating tags. An interview with the Director of Maintenance	K 761	Facility is obtaining quotes from vendors to identify a workplan and date for installation of the fire rating tags on the doors that require fire rating tags. Facility will complete an audit of doors around the perimeter of areas identified as “hazardous areas”, per the floor plan reviewed with the Fire Marshal on 3/20/2024, to ensure doors that require fire rating tags have tags. Facility will select a vendor and identify a workplan and a date to install the fire rating tags on the doors that require the fire rating tags.	4/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245511	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH MONTICELLO	**1013 HART BOULEVARD** **MONTICELLO, MN 55362**

(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
K 761	Continued From page 6 verified these deficient findings at the time of discovery.	K 761	Facility will add to annual door inspection document to inspect for fire rating tags on the doors that require fire rating tags. Administrator, or designee, will audit the annual door inspection document to ensure compliance with tags being in place on the doors that require fire rating tags. This audit will occur for one year and then as determined by the Quality Assurance committee thereafter. Administrator, or designee, will identify a vendor, workplan and installation date to install fire rating tags on the doors that require the tags and will complete an audit of the annual door inspection document for one year and then as determined by the Quality Assurance Committee thereafter.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 9, 2024

Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, MN 55077

RE: CCN: 245320
Cycle Start Date: March 5, 2024
In reference to surveys exited on March 5, 2024, and March 14, 2024.

Dear Administrator:

On April 11, 2024, the Minnesota Department(s) 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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