



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
November 7, 2024

Administrator  
St. Therese Home  
8000 Bass Lake Road  
New Hope, MN 55428-3118

RE: CCN: 245518  
Cycle Start Date: October 25, 2024

Dear Administrator:

On October 25, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

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

*An equal opportunity employer.*

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

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

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

## DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor  
St. Cloud B District Office  
Health Regulation Division  
Minnesota Department of Health  
4140 Thielman Lane  
Saint Cloud, Minnesota 56301-4557  
Email: [judy.loecken@state.mn.us](mailto:judy.loecken@state.mn.us)  
Office: (320) 223-7300 Mobile: (320) 241-7797

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or



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Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 25, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 25, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

#### **INFORMAL DISPUTE RESOLUTION (IDR)**

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

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

#### **INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

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

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<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

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

Travis Z. Ahrens  
State Fire Safety Supervisor  
Health Care & Correctional Facilities  
MN Department of Public Safety-Fire Marshal Division  
445 Minnesota St., Suite 145  
St. Paul, MN 55101  
Email: [travis.ahrens@state.mn.us](mailto:travis.ahrens@state.mn.us)  
Web: [www.sfm.dps.mn.gov](http://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](mailto:holly.zahler@state.mn.us)

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

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FORM APPROVED  
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245518</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                             |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/25/2024</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| E 000                                                                                    | Initial Comments<br><br>On 10/22/24 through 10/25/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance.<br><br>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.<br><br>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 025<br>SS=C                                                                            | Arrangement with Other Facilities<br>CFR(s): 483.73(b)(7)<br><br>§403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] |                                                                            |  | E 025                                                                                            |                                                                                                                          |                                                                    | 11/29/24                   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/16/2024

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.

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

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b> |                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                    |                            |
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| E 025                                                                                    | <p>Continued From page 1</p> <p>*[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview and document review, the facility failed to develop arrangements with other facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. This had the potential to affect all 159 residents residing in the facility.</p> <p>Findings include:</p> |                                                                            |  | E 025                                                                                            | <p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible</p> |                                                                    |                            |

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| E 025                                                                                    | <p>Continued From page 2</p> <p>Review of the facility's Emergency Preparedness (EP) plan identified the facility did not have any written agreements or contracted arrangements with other facilities to receive residents in the event of limitations or cessation of operation to maintain the continuity of services to facility residents.</p> <p>On 10/25/24 at 2:50 p.m., the administrator confirmed the facility did not have any valid agreements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. The administrator stated the facility should have prearranged agreements with other facilities to receive residents.</p> <p>The facility's Emergency Preparedness Committee policy, dated 2021, indicated the facility would establish agreements or contracts with local agencies and businesses to maintain continuity of care and provide contingencies and cooperative arrangements that may be necessary prior to, during, and after emergencies.</p> | E 025                                                                      | <p>allegation of compliance.</p> <p>The community has policies and procedures related to Emergency Preparedness and the requirement to establish agreements or contacts with local agencies and businesses to maintain the continuity of care and provide contingencies and arrangements in the event of an emergency.</p> <p>These policies have been reviewed and updated and remain current.</p> <p>The community has a completed transfer agreements.</p> <p>The administrator or designee will review the agreements at the next QAPI meeting. Emergency binder will be reviewed annually and ongoing as needed to ensure agreements will remain current. Administrator and/or designee will be responsible for oversight and monitoring. The results will be reviewed with the facility QAPI committee for further input and if the agreements satisfy the size and needs of our community. Any recommendations will be addressed.</p> |                            |                                                                    |
| E 039<br>SS=C                                                                            | <p>EP Testing Requirements<br/>CFR(s): 483.73(d)(2)</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | E 039                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 11/29/24                   |                                                                    |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b>                         |                            |                                                                    |
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| E 039                                                                                    | <p>Continued From page 3</p> <p>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br/>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br/>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br/>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br/>(B) A mock disaster drill; or<br/>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245518</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                             |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/25/2024</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |  | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| E 039                                                                                    | <p>Continued From page 4</p> <p>exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct</p> |                                                                            |  | E 039                                                                                            |                                                                                                                          |                                                                    |                            |

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| E 039                                                                                    | <p>Continued From page 5</p> <p>exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |



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| E 039                                                                                    | <p>Continued From page 6</p> <p>is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |

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| E 039                                                                                    | <p>Continued From page 7</p> <p>accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |

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| E 039                                                                                    | <p>Continued From page 8</p> <p>accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from</p> |                                                                            |  | E 039                                                                                            |                                                                                                                          |                                                                    |                            |

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| E 039                                                                                    | <p>Continued From page 9</p> <p>engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b> |                                                                                                                          |                                                                    |                            |
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| E 039                                                                                    | <p>Continued From page 10</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain</p> |                                                                            |  | E 039                                                                                            |                                                                                                                          |                                                                    |                            |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                                                                    |
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| E 039                                                                                    | <p>Continued From page 11</p> <p>documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[ RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to conduct exercises to test their emergency preparedness (EP) plan at least twice per year, . This had the potential to affect all 159 residents who currently resided in the facility.</p> <p>Findings include:</p> <p>Review of the facility's EP plan identified the facility had not conducted an additional second exercise to test their EP plan that included a potential second full-scale exercise, a mock disaster drill, or an additional tabletop exercise, and analyze the facility's response to that additional exercise.</p> <p>On 10/25/24 at 2:50 p.m., the administrator confirmed there was no documentation to support</p> | E 039                                                                      | <p>The community has policies and procedures related to Emergency Preparedness and the requirement to establish agreements or contacts with local agencies and businesses to maintain the continuity of care and provide contingencies and arrangements in the event of an emergency.</p> <p>These policies have been reviewed and updated and remain current.</p> <p>Table top exercise will be completed on 11/20/2024.</p> <p>Administrator and/or designee will be responsible for oversight and monitoring. Emergency binder will be reviewed</p> |                            |                                                                    |

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| E 039                                                                                    | Continued From page 12<br>an additional exercise had been performed in the<br>EP plan documentation. The administrator stated<br>the facility should have completed exercises to<br>test their EP plan at least twice per year.<br><br>The facility's Emergency Preparedness<br>Committee policy, dated 2021, indicated the<br>facility would ensure testing requirements were<br>completed as planned in accordance with<br>guidance.                                                                                                                                                                                                                                                                                                                                                                                                                                      | E 039                                                                      | annually and ongoing as needed to<br>ensure emergency exercises are<br>maintained per regulatory requirements.<br>The community has signed up for the<br>Metro Emergency Preparedness Coalition<br>email blasts and will stay connected with<br>the Coalition on ongoing table tops and/or<br>community wide exercises. The<br>administrator or designee will review and<br>share the tabletop with the facility QAPI<br>committee and will receive feedback<br>regarding emergency readiness. Any<br>recommendations will be addressed. |                            |                                                                    |
| F 000                                                                                    | INITIAL COMMENTS<br><br>On 10/22/24 through 10/25/24, a standard<br>recertification survey was conducted at your<br>facility. A complaint investigation was also<br>conducted. Your facility was NOT in compliance<br>with the requirements of 42 CFR 483, Subpart B,<br>Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed with NO<br>deficiencies cited: H55189383C (MN107138);<br>H55189403C (MN103332); H55189404C<br>(MN104020); H55189405C (MN101729);<br>H55189408C (MN100829); H55189422C<br>(MN106452); H55189448C (MN102570);<br>H55189765C (107717)<br><br>AND<br><br>The following complaint was reviewed:<br>H55189409C (MN105723) with deficiencies cited<br>at F550, F677, and deficient practice was<br>identified related to incidental findings at F689.<br><br>The facility's plan of correction (POC) will serve | F 000                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                            |                                                                    |

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| F 000                                                                                    | Continued From page 13<br>as your allegation of compliance upon the<br>Departments acceptance. Because you are<br>enrolled in ePOC, your signature is not required<br>at the bottom of the first page of the CMS-2567<br>form. Your electronic submission of the POC will<br>be used as verification of compliance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | F 000                                                                      |                                                                                                                          |                            |                                                                    |
| F 550<br>SS=D                                                                            | Upon receipt of an acceptable electronic POC, an<br>onsite revisit of your facility may be conducted to<br>validate substantial compliance with the<br>regulations has been attained.<br><br>Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence,<br>self-determination, and communication with and<br>access to persons and services inside and<br>outside the facility, including those specified in<br>this section.<br><br>§483.10(a)(1) A facility must treat each resident<br>with respect and dignity and care for each<br>resident in a manner and in an environment that<br>promotes maintenance or enhancement of his or<br>her quality of life, recognizing each resident's<br>individuality. The facility must protect and<br>promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal<br>access to quality care regardless of diagnosis,<br>severity of condition, or payment source. A facility<br>must establish and maintain identical policies and<br>practices regarding transfer, discharge, and the<br>provision of services under the State plan for all<br>residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights. | F 550                                                                      |                                                                                                                          | 11/29/24                   |                                                                    |



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| F 550                                                                                    | <p>Continued From page 14</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, and record review the facility failed to provide and maintain dignity for 1 of 1 residents (R106) reviewed for dignity.</p> <p>Findings Include:</p> <p>R106's quarterly minimum data set (MDS) dated 6/17/24, indicated a severely impaired cognition, diagnosis of dementia (a group of symptoms affecting memory, thinking and social abilities) and required extensive assistance for dressing, grooming and toileting.</p> <p>R106's care plan dated 7/21/24, indicated R106 required extensive assist of 1 staff for dressing and grooming. The care plan did not indicate if R106 preferred to wear her own clothes or a hospital type gown.</p> <p>On 10/22/24 at 3:26 p.m., R106 was in her room, sitting in her wheelchair wearing a white with blue</p> | F 550                                                                      | <p>Dignity has been provided and maintained for R106. She is dressed in appropriately fitting clothes daily and her hair is neat and clean.</p> <p>Residents residing at Woodlake have the potential to be affected. Dignity has been provided and maintained for all identified residents. Residents are dressed in appropriately fitting clothes daily and their hair is neat and clean.</p> <p>Nursing staff have been educated on the requirements to provide and maintain dignity to residents who are dependent on staff for ADLs. They have been educated to ensure residents are dressed daily in clothes that are clean and fit appropriately. They have been educated on providing hair care daily and as needed so residents appearance is neat, clean, and dignified.</p> |                            |                                                                    |

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| F 550                                                                                    | <p>Continued From page 15</p> <p>flowers hospital type gown. R106 did not have on any type of footwear. R106's hair was uncombed and had areas that appeared to be matted and other areas that stood up approximately 2 inches from her scalp.</p> <p>During observation and interview on 10/22/24 at 3:31 p.m. certified nursing assistant (CNA)-A assisted R106 to bed and stated she was familiar with R106 but didn't typically work with her during the day shift. CNA-A stated R106 was usually dressed in a gown but was unable to confirm if R106 preferred to be dressed in her own clothes.</p> <p>On 10/25/24 at 10:11 a.m. R106 was observed in bed wearing a white with blue flowered hospital type gown.</p> <p>On 10/25/24 at 11:48 a.m. R106 was observed in her wheelchair being pushed in the hallway in the direction of the dining room. R106 was wearing a white with blue flowered hospital gown and a pair of dark colored pant and yellow gripper socks. The hem on R106's pants was approximately 4 inches above her ankles. R106's hair was not combed.</p> <p>During interview on 10/25/24 at 10:41 a.m., CNA-B stated she was familiar with R106 and stated she liked to be dressed every day and frequently wore hospital gowns. CNA-B stated she knew how to take care of R106 as her cares were listed on a care sheet taped to the inside of the closet door. CNA-B was unable to indicate on the care sheet if R106 preferred to wear her own clothes or a hospital gown.</p> <p>During interview on 10/25/24 at 11:01 a.m., CNA-C stated she was familiar with R106 and</p> | F 550                                                                      | <p>Audits to ensure dignity is being provided and maintained for the residents including but not limited to ensuring they are dressed in clean appropriately fitting clothes and hair care is completed to maintain a dignified appearance will be completed by DON/designee. The audit schedule will be as follows: 4 residents 3 x per week x 4 weeks, then 3 residents 3 x per week x 3 weeks, then 2 residents 2 x per week x 2 weeks then, 1 resident weekly x 1 month. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                                    |

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| F 550                                                                                    | <p>Continued From page 16</p> <p>had assisted her to get ready for the day that morning. CNA-C stated R106 required assistance to get dressed every day as well as help with her oral care and brushing her hair. CNA-C stated she did not know if R106 preferred her own clothes or a hospital gown, nor did she know where to find that information.</p> <p>During interview on 10/25/24 at 1:11 p.m., R106's family member (FM)-A stated R106 preferred to wear her own clothes every day and took great pride in her appearance. FM-A went on to say at a recent appointment R106 had been dressed in pants that were too short, was not wearing a bra under her shirt and her hair was messy. FM-A stated R106 would never have left her house looking like that. She continued to say R106 had many nice matching tops and bottoms but was rarely dressed in anything except a hospital gown. She stated her mom used to always try to look nice and it would make her sad to not be dressed nice with her hair neat.</p> <p>During interview on 10/25/24, at 11:19 a.m., the director of nursing (DON) stated R106 required assistance with getting dressed, oral care, grooming and toileting. She stated staff could look at R106's care plan located inside her closet door to see preferences for R106. DON stated she expected staff to assist residents to wear clean, neat clothing and to comb their hair to help residents to feel good about their appearance. DON stated it was important for residents to feel good about how they looked, and it was a matter of dignity for themselves. DON stated residents emotional well being could be negatively affected if they didn't feel good about their physical appearance.</p> | F 550                                                                      |                                                                                                                          |                            |                                                                    |

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| F 550                                                                                    | Continued From page 17<br>Facility policy titled Promoting/Maintaining<br>resident dignity, dated October 2022 indicated the<br>following: The resident's former lifestyle and<br>personal choices will be considered when<br>providing care and services to meet the resident's<br>needs and preferences. Groom and dress<br>residents according to resident preferences.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | F 550                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                    |
| F 554<br>SS=D                                                                            | Resident Self-Admin Meds-Clinically Approp<br>CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer<br>medications if the interdisciplinary team, as<br>defined by §483.21(b)(2)(ii), has determined that<br>this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on observation, interview and document<br>review, the facility failed to ensure residents were<br>comprehensively assessed for self-administration<br>of medications for 1 of 1 resident (R423)<br>reviewed.<br><br>Findings include:<br><br>R423's annual Minimum Data Set (MDS) dated<br>9/9/24, identified R423's cognition as moderately<br>impaired and needed assistance with of one staff<br>with activities of daily living (ADL's).<br><br>During an observation on 10/24/24 at 7:45 a.m.,<br>R423 was laying in her bed with lights on. R423<br>had a tube of Asper Crème (treats muscle and<br>joint pain), a container of petroleum jelly, and two<br>bottles of Nystatin powder in the yellow bin next to<br>the nightstand and unsecured. R423 stated the<br>nursing assistant (NA) "put that on for me".<br><br>During medical record review on 10/24/24, the | F 554                                                                      | Resident #423 continues to not be<br>appropriate to self-administer<br>medications. The Asper creme, petroleum<br>jelly, and nystatin topical powder bottles<br>have been removed from her room. The<br>resident's medications are only being<br>administered by nurses or TMAs.<br><br>Residents residing at Woodlake have the<br>potential to be affected. All residents have<br>been reviewed. Residents identified as<br>self-administering medications and<br>keeping at bedside have a current<br>self-medication assessment and order.<br>They have a secure location to store the<br>medications, and the medications are not<br>expired. Medication administration is only<br>being conducted by nurses or TMAs.<br><br>Nursing staff have been educated that<br>only residents with orders and<br>assessments indicating they are safe to |  | 11/29/24                                                           |

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| F 554                                                                                    | <p>Continued From page 18</p> <p>medical record lacked evidence of an assessment for self-administering medications (SAM) being completed. The medical record lacked evidence of a physician order for a SAM.</p> <p>During an interview on 10/24/24 at 9:33 a.m., NA-A stated R423 requested the contents of the yellow tube of crème on her shoulders for pain and "I [NA-A] did on 10/18/24 around supper time".</p> <p>During a tour of R423 room on 10/24/24 at 1:26 p.m. nurse manager (NM)-A revealed a five-ounce Asper crème tube with 10% trolamine salicylate that expired 2/24. A 13-ounce petroleum jelly container and two bottles of nystatin topical powder 30 grams each which were low in content. One had expired 6/16/24 and the other 2/19/24.</p> <p>During an interview on 10/24/24 at 1:56 p.m., NM-A stated R423 did not have a SAM order and no assessment to SAM. NM-A stated R423 could not apply the creams and powder by themselves. NM-A stated R423 was not to have medications in her room without an order. NM-A stated she did not know the medications were in the room. NM-A stated the NAs were not trained to put on topical creams and powders.</p> <p>During an interview on 10/24/24 at 2:22 p.m., the director of nursing (DON) stated the NAs cannot put on creams and powders, only the nurses.</p> <p>The facility policy Self Administration of Medications dated 8/24, indicated a resident may only self-administer medications after the facility's has evaluated the resident and determined which medications may be self-administered safely. The</p> | F 554                                                                      | <p>self-administer medications and store at bedside are allowed to have medications left in their rooms. They were educated that medications must be stowed in a secured location and must not be expired. They have been educated that only a Nurse or a TMA may administer or apply medications, including but not limited to topical over-the-counter medication or creams, ointments, powders, or lotions.</p> <p>Audits will be completed to ensure only nurses or TMAs are administering medications. Additionally, the audit will include monitoring of residents to ensure that only residents who have been assessed as safe to administer medications and stow at the bedside will have medications secured in their room. These medications will be audited to ensure they are not expired.</p> <p>Audits will be completed by DON/designee. The audit schedule will be as follows: 4 residents 3 x per week x 4 weeks, then 3 residents 3 x per week x 3 weeks, then 2 residents 2 x per week x 2 weeks then, 1 resident weekly x 1 month. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                                    |

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| F 554                                                                                    | Continued From page 19<br>nursing staff is responsible for proper rotation of<br>bedside stock and removal of expired<br>medications.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | F 554                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11/29/24                   |                                                                    |
| F 677<br>SS=D                                                                            | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry<br>out activities of daily living receives the necessary<br>services to maintain good nutrition, grooming, and<br>personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on observation, interview and record<br>review, the facility failed to ensure assistance with<br>dressing and grooming for 1 of 3 residents<br>(R106) reviewed for activities of daily living (ADL)<br>care provided for dependent residents.<br><br>Finding include:<br><br>R106's quarterly Minimum Data Set (MDS) dated<br>6/17/24, indicated severely impaired cognition,<br>diagnosis of dementia (a group of symptoms<br>affecting memory, thinking and social abilities)<br>and required extensive assistance for dressing,<br>grooming, bathing, oral cares and toileting. The<br>MDS indicated R106 did not reject or refuse<br>cares.<br><br>R106's care plan dated 7/21/24, indicated R106<br>had an ADL deficit related to dementia and<br>required extensive assist of 1 staff for dressing,<br>grooming, bathing, and elimination. The care plan<br>indicated R106 would receive the necessary<br>assistance with all ADL's. The care plan also<br>indicated R106 did not have any natural teeth and<br>instructed staff to assist with denture placement<br>every AM and removal every PM. The care plan | F 677                                                                      | Resident's R106 has had hand hygiene<br>completed. The resident's wig has been<br>combed and is neat and clean. The<br>resident has had oral care completed and<br>assistance with denture placement.<br><br>Residents residing at Woodlake who are<br>dependent on staff for ADLs have the<br>potential to be affected. ADL assistance<br>has been provided to identified residents<br>per their plan of care and Kardex<br>instructions. All residents hair has been<br>combed and is neat and clean. All<br>residents requiring assistance with hand<br>hygiene, oral care, and placement of<br>dentures have had these tasks<br>completed.<br><br>Nursing staff have been educated on<br>following the plan of care and Kardex<br>instruction when caring for residents.<br>They have been taught where to find this<br>information. They have been educated on<br>the requirement of providing residents<br>assistance with grooming tasks, including<br>but not limited to combing hair, assisting |                            |                                                                    |

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| F 677                                                                                    | <p>Continued From page 20</p> <p>instructed staff to encourage and assist R106 to perform proper hand hygiene on hands and nails before snacks and meals. The care plan did not indicate R106 preference to wear her own clothes or hospital type gowns.</p> <p>On 10/22/24 at 3:26 p.m., R106 was sitting in her room, in a wheelchair wearing a white with blue flowered hospital type gown. R106 did not have on any footwear. R106's hair was messy, uncombed with areas that were matted and others that stood up approximately 2 inches from her scalp. Certified nursing assistants (CNA)-A and D entered R106's room and transferred R106 from her wheelchair to bed using a ceiling lift. Upon completion of transfer CNA-A gave an opened package of chocolate frosted cookies to R106. R106 immediately began taking cookies out of the package and put them into her mouth. CNA-A did not assist R106 with hand hygiene.</p> <p>During interview on 10/22/24 at 3:31 p.m., CNA-A stated she was familiar with R106, her cares, and required assistance with dressing and toileting. CNA-A stated she knew how to care for R106 by looking at the care plan taped to the inside of the door of the closet. CNA-A pointed to the care plan and identified R106's cares were dressing, personal grooming, denture care and toileting. CNA-A stated R106 didn't have her dentures in at that time and confirmed she did not provide hand hygiene prior to giving R106 the opened package of cookies.</p> <p>On 10/25/24 at 10:11 a.m., R106 was lying in her bed wearing a white with blue flowers hospital type gown. R106's hair was messy, uncombed, and an opened package of chocolate frosted cookies was on the bed next to residents left</p> | F 677                                                                      | <p>with oral care, and placing dentures if applicable.</p> <p>Audits will be completed to ensure ADL assistance is occurring including but not limited to hand hygiene, hair care, oral hygiene, and assistance with denture placement by DON/designee. The audit schedule will be as follows: 4 residents 3 x per week x 4 weeks, then 3 residents 3 x per week x 3 weeks, then 2 residents 2 x per week x 2 weeks then, 1 resident weekly x 1 month. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                                    |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b>                         |                            |                                                                    |
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| F 677                                                                                    | <p>Continued From page 21 hand.</p> <p>During interview on 10/25/24 at 11:01 a.m., CNA-C stated she was familiar with R106's care and frequently assisted her. CNA-C stated she had assisted R106 to get ready earlier that day. CNA-C stated R106 needed assistance getting dressed every day as well as help with her oral care and brushing her hair. CNA-C stated she did not know if R106 preferred her own clothes or a hospital gown, nor did she know where to find that information. CNA-C stated she had not assist R106 with hair care or denture/oral cares during morning cares.</p> <p>On 10/25/24 at 11:48 a.m., R106 was in her wheelchair being pushed towards the dining room by an unidentified staff member. R106 was wearing a white with blue flowered hospital gown and a pair of dark colored pants with yellow gripper socks. The hem on R106's pants was approximately 4 inches above her ankles. R106's hair was messy and uncombed.</p> <p>During interview on 10/25/24 at 1:11 p.m., family member (FM)-A stated R106 preferred to wear her own clothes every day and took great pride in her appearance. FM-A stated R106 always tried to look nice, and it would make her sad to not be dressed nice with her hair neat.</p> <p>During interview on 10/25/24 at 11:19 a.m., the director of nursing (DON) stated R106 required assistance with getting dressed, oral care, grooming and toileting. Staff should look at the care plan located inside the closet door to see preferences for R106. DON confirmed R106 did not prefer to wear hospital gowns. DON stated she expected staff to assist residents to wear</p> | F 677                                                                      |                                                                                                                          |                            |                                                                    |



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245518</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                             |                                                                                                                                                                                                                                                                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/25/2024</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b> |                                                                                                                                                                                                                                                                                                     |                                                                    |                            |
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| F 677                                                                                    | Continued From page 22<br>clean, neat clothing and to comb their hair to help residents to feel good about their appearance. DON stated she expected staff to assist every resident with all necessary ADL's. DON stated assisting residents with ADL cares was beneficial to a residents physical and emotional health.<br><br>Facility policy titled Activities of daily living (ADL's) dated January 2023 indicated the facility will provide care and services for activities of daily living to include, bathing, dressing, grooming and oral care. The policy further indicated any resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. |                                                                            |  | F 677                                                                                            |                                                                                                                                                                                                                                                                                                     |                                                                    |                            |
| F 689<br>SS=D                                                                            | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure care plan interventions were being utilized for 1 of 2 residents (R106) reviewed for safety.<br><br>Findings include:<br><br>R106's quarterly Minimum Data Set (MDS) dated 6/17/24, indicated severely impaired cognition,                                           |                                                                            |  | F 689                                                                                            | The resident's R106 call light has been placed within her reach. The call light has a clip attached to it.<br><br>Residents residing at Woodlake have the potential to be affected. All residents have call lights placed within reach. All call lights have clips attached so they can be secured. |                                                                    | 11/29/24                   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                                                                    |
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| F 689                                                                                    | <p>Continued From page 23</p> <p>diagnosis of dementia (a group of symptoms affecting memory, thinking and social abilities) and required extensive assistance for dressing, grooming and toileting.</p> <p>R106's care plan revised on 9/15/24, indicated R106 was at risk for falls and had a history of falls. Interventions included staff assistance by placing the call light where the resident can reach it before exiting the room each time, and ensure all personal belongings are within reach for the resident.</p> <p>During continuous observation on 10/25/24 beginning at 10:11 a.m. through 11:06 a.m., R106 was lying in her bed. A white call light with a red button to push for assistance was noted to be lying on the floor under the bedside table approximately 2 feet away, outside of R106's reach. There was no clip to attach the call light noted on the call light cord. No other call light was noted in the room.</p> <p>During interview on 10/25/24 at 10:41 a.m., certified nursing assistant (CNA)-B stated R106 was functionally able to use the call light if she needed staff assistance. CNA-B stated R106 had both a soft touch call light and one with a button to push for assistance. CNA-B stated R106 would primarily use the white call light with the red button because she was most familiar with that type. CNA-B stated she would clip the call light to the blankets or the wheelchair to keep it within reach of R106.</p> <p>During interview on 10/25/24 at 11:01 a.m. CNA-C entered R106's room and confirmed R106's white call light was lying on the floor outside of R106's reach, and there was no other</p> | F 689                                                                      | <p>Staff have been educated that call lights are to be within reach of the resident and secured to ensure placement if needed.</p> <p>Audits will be completed by the Administrator/Designee to ensure call lights are within reach of residents and that there are clips attached to them to use to secure if needed. The audit schedule will be as follows: 4 residents 3 x per week x 4 weeks, then 3 residents 3 x per week x 3 weeks, then 2 residents 2 x per week x 2 weeks then, 1 resident weekly x 1 month. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                                    |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b> |                                                                                                                          |                                                                    |                            |
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| F 689                                                                                    | <p>Continued From page 24</p> <p>call light available within reach of R106. CNA-C stated R106 was functionally able to use her call light appropriately to summon for help if needed. CNA-C stated she had clipped the call light the blankets on the bed before her break and didn't know how it got on the floor. CNA-C stated without the call light R106 would have to yell out to get help. CNA-C stated she was unsure if staff in another room would be able to hear R106 if she was calling out.</p> <p>During interview on 10/25/24 at 11:19 a.m., the director of nursing (DON) stated all resident should have a call light or device within their reach to summon staff for assistance whenever staff left the room. DON stated she expected staff to either hand the call light directly to the resident or clip it the residents clothing or blankets. DON stated this was extremely important for residents' safety and for residents to be able to communicate their need of assistance to staff.</p> <p>Facility policy title Call lights: accessibility and timely response dated January 2023 indicated each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call light system. Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.</p> |                                                                            |  | F 689                                                                                            |                                                                                                                          |                                                                    |                            |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b>   |                                                                                                                          |                                                        |                            |
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| K 000                                                                                    | <p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/23/2024. At the time of this survey, St Therese Home (name changed to Woodlake At New Hope) 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.</p> <p>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.</p> <p>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.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p> |                                                                            |  | K 000                                                                                              |                                                                                                                          |                                                        |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/16/2024

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                                                                                    | <p>Continued From page 1</p> <p>Healthcare Fire Inspections<br/>State Fire Marshal Division<br/>445 Minnesota St., Suite 145<br/>St. Paul, MN 55101-5145, OR</p> <p>By email to:<br/>FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH<br/>DEFICIENCY MUST INCLUDE ALL OF THE<br/>FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> <li>1. A detailed description of the corrective action<br/>taken or planned to correct the deficiency.</li> <li>2. Address the measures that will be put in<br/>place to ensure the deficiency does not reoccur.</li> <li>3. Indicate how the facility plans to monitor<br/>future performance to ensure solutions are<br/>sustained.</li> <li>4. Identify who is responsible for the corrective<br/>actions and monitoring of compliance.</li> <li>5. The actual or proposed date for completion of<br/>the remedy.</li> </ol> <p>St Therese Home (name changed to Woodlake<br/>At New Hope) is a 3-story building with no<br/>basement. The building was constructed at four<br/>different times. The original building was<br/>constructed in 1968 and was determined to be of<br/>Type I (332) construction. In 1973, an addition<br/>was constructed to the 3rd floor that was<br/>determined to be of Type II (111) construction. In<br/>1999, an addition was constructed to the west<br/>side of the 1st floor that was determined to be of</p> | K 000                                                                      |                                                                                                                          |                            |                                                        |

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| K 000                                                                                    | Continued From page 2<br>Type I (332). Another addition was constructed in 2003 to the 2nd and 3rd floor that was determined to be of Type I (332). Because the 3rd floor was determined to be Type II (111), the building was downgraded to Type II (111). Being that the construction type is allowed for an existing building of this height, the building is surveyed as one building. The building is fully automatic fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification.<br><br>The facility has a capacity of 188 beds and had a census of 160 at the time of the survey.     | K 000                                                                      |                                                                                                                                                      |                            |                                                        |
| K 211<br>SS=E                                                                            | The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:<br>Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain egress paths per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. These deficient | K 211                                                                      | Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also | 11/29/24                   |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245518</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 211                                                                                    | Continued From page 3<br>findings could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 10/23/2024 at 11:37 AM, it was revealed by observation that a patient lift was blocking the emergency exit door near resident room 237.<br><br>2. On 10/23/2024 at 12:05 PM, it was revealed by observation that there was a desk with a laptop and chair in the egress corridor near resident room 156.<br><br>3. On 10/23/2024 at 12:14 PM, it was revealed by observation that a bed, boxes and a chair were being stored in the egress corridor outside of the boiler room.<br><br>4. On 10/23/2024 at 12:22 PM, it was revealed by observation that a pallet, microwave, recliner chair, and a fan were being stored in the egress corridor near the loading dock.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified these deficient findings at the time of discovery. | K 211                                                                      | not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br><br>Findings 1-4 items were immediately moved or cleaned out of the path of egress as areas of concern were identified.<br><br>Education will be provided to staff on blocking emergency exits, furniture and storage in the egress corridor in resident care units, in the loading dock, and in maintenance hallways.<br><br>Administrator, Plant Operations Director, or designee will audit emergency exits and egress corridors for compliance as it relates to blockage and storage in the means of exit and egress. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 321<br>SS=D                                                                            | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | K 321                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11/29/24                   |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                        |                            |                                                        |
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| K 321                                                                                    | <p>Continued From page 4</p> <p>system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler<br/>Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms<br/>b. Laundries (larger than 100 square feet)<br/>c. Repair, Maintenance, and Paint Shops<br/>d. Soiled Linen Rooms (exceeding 64 gallons)<br/>e. Trash Collection Rooms (exceeding 64 gallons)<br/>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br/>g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/23/2024 at 11:45 AM, it was revealed by observation that the door to the soiled utility room</p> | K 321                                                                      | <p>Identified material stored in the strike plate was immediately removed and the door positively latched.</p> <p>Education will be provided to staff related to the requirement of maintaining hazardous rooms per the life safety code. Education will specifically call out examples of stuffing garbage bags, paper towel, or any other item into the door strike plates that prevents hazardous materials from being locked.</p> |                            |                                                        |



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| K 321                                                                                    | Continued From page 5<br>106 had a trash bag stuffed into the strike plate causing the door to not positively latch.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | K 321                                                                      | Administrator, Plant Operations Director, or designee will audit all hazardous materials storage rooms to ensure the door positively latches and nothing is stored inside the door's strike plate. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 324<br>SS=E                                                                            | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 | K 324                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 11/29/24                   |                                                        |

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| K 324                                                                                    | <p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. These deficient findings could have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>1. On 10/23/2024 at 11:52 AM, it was revealed by observation that the residential stove located in the first floor west resident lounge does not have a locked switch, or a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action.</p> <p>2. On 10/23/2024 at 12:10 PM, it was revealed by observation that the residential stove located in the first floor east resident lounge does not have a locked switch, or a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action.</p> <p>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified these deficient findings at the time of discovery.</p> | K 324                                                                      | <p>On findings 1-2, during the survey stoves were immediately turned off.</p> <p>The electrical power cords were removed from the stove to prevent any future use. Staff and residents will be notified that the ovens are for decorative purposes only moving forward and will no longer function unless requirements are met by NFPA 101 (2012 edition) and Life Safety Code requirements as it relates to cooking facilities.</p> <p>The Administrator, Plant Operations Director, or designee is responsible for ensuring the stove lines are turned off and no longer functional. Findings and solutions will be shared with the facility QAPI committee. Discrepancies will be addressed and corrected.</p> |                            |                                                        |

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| K 345<br>SS=D                                                                            | <p>Fire Alarm System - Testing and Maintenance<br/>CFR(s): NFPA 101</p> <p>Fire Alarm System - Testing and Maintenance<br/>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br/>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on observation and staff interview, the facility failed to maintain access to fire alarm pull stations per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3 and 9.6.2.7, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 17.14.5. This deficient finding could have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/23/2024 at 11:37 AM, it was revealed by observation that the fire alarm pull station near resident room 237 was blocked by a patient lift being left in front of it.</p> <p>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery.</p> | K 345                                                                      | <p>Findings noted during the survey were immediately moved from blocking the fire pull station.</p> <p>Education will be provided to staff on blocking fire pull stations and fire extinguishers with equipment in accordance with Fire Alarm System Testing and Maintenance standards of the Life Safety Code.</p> <p>Administrator, Plant Operations Director, or designee will audit fire alarm pull stations and fire extinguisher for blockage. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> | 11/29/24                   |                                                        |
| K 355<br>SS=D                                                                            | <p>Portable Fire Extinguishers<br/>CFR(s): NFPA 101</p> <p>Portable Fire Extinguishers<br/>Portable fire extinguishers are selected, installed,</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | K 355                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11/29/24                   |                                                        |

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| K 355                                                                                    | <p>Continued From page 8</p> <p>inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br/>18.3.5.12, 19.3.5.12, NFPA 10</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, a review of available documentation, and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/23/2024 at 11:58 AM, it was revealed by observation that the fire extinguisher located in the elevator mechanical room on the first floor had the last annual maintenance completed in August of 2023.</p> <p>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery.</p> | K 355                                                                      | <p>Plant Operations Director contacted Summit Fire to come out to the community to inspect the un-marked fire extinguisher noted during the survey. The non-inspected portable fire extinguisher was removed and replaced with one that is compliant.</p> <p>An audit of portable fire extinguishers in the community to be completed to ensure other fire extinguishers have been maintained appropriately.</p> <p>Administrator, Plant Operations Director, or designee will be responsible for auditing and monitoring. Audits will be monthly x 2 months. Plant operations director, or designee will maintain a list of all fire extinguishers in the community to ensure the vendor does not miss any portable fire extinguishers in the future. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                        |
| K 363<br>SS=E                                                                            | <p>Corridor - Doors</p> <p>CFR(s): NFPA 101</p> <p>Corridor - Doors</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | K 363                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11/29/24                   |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245518</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                              |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                               |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 363                                                                                    | <p>Continued From page 9</p> <p>hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section</p> | K 363                                                                      | <p>All objects propping doors open that were identified in points 1-3 during the survey were removed immediately.</p>    |                            |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                            |                                                        |
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| K 363                                                                                    | Continued From page 10<br>19.3.6.3.10. These deficient findings could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 10/23/2024 at 11:11 AM, it was revealed by observation that the door to office 364A conference room was held open with a trash can.<br><br>2. On 10/23/2024 at 11:12 AM, it was revealed by observation that the door to resident room 363 was being held open with a chair.<br><br>3. On 10/23/2024 at 11:43 AM, it was revealed by observation the door to office 106 was being held open with a block of wood.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified these deficient findings at the time of discovery. | K 363                                                                      | Education will be provided to staff on the requirements of Corridor-Doors as outlined in K363. The education will be specifically surrounded by doors being propped open with objects.<br><br>Administrator, Plant Operations Director, or designee will audit corridor doors being propped open with any sort of object. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 511<br>SS=D                                                                            | Utilities - Gas and Electric<br>CFR(s): NFPA 101<br><br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br><br>This REQUIREMENT is not met as evidenced                                                                                                                                                                                                                                                                                                                                          | K 511                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 11/29/24                   |                                                        |

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| K 511                                                                                    | Continued From page 11<br>by:<br>Based on observation and staff interview, the facility failed to maintain the electrical system per NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and NFPA 70 (2011 edition), Life Safety Code, section 314.25. These deficient findings could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 10/23/2024 at 10:28 AM, it was revealed by observation that there was an open electrical junction box above the ceiling near office 301 Director of Social Services.<br><br>2. On 10/23/2024 at 11:00 AM, it was revealed by observation that the electrical breaker panel near resident room 327 was not locked.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified these deficient findings at the time of discovery. | K 511                                                                      | All open electrical junction boxes and breaker panels were secured and closed upon findings during the survey.<br><br>Education will be provided to maintenance staff on the requirements of electrical junction boxes and electrical breaker panels being secured and locked.<br><br>Administrator, Plant Operations Director, or designee will audit on breaker boxes and electrical junction boxes to ensure they are properly secured and locked. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 918<br>SS=F                                                                            | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance                                                                                                                                                                                                                                                                                                                                                                                                                      | K 918                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 11/29/24                   |                                                        |

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| K 918                                                                                    | <p>Continued From page 12</p> <p>with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2 and 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/23/2024 between 09:15 AM and 01:00 PM,</p> |                                                                            |  | K 918                                                                                       | <p>Plant Operations Director called Allied and scheduled the annual load bank test.</p> <p>Load bank test was completed on 11/6/2024 from 9 am - 2 pm. Report was sent on 11/11/2024 and put in the binder.</p> <p>Administrator, Plant Operations Director, or designee will audit the community's life safety binder to ensure all necessary documentation and tasks have been completed. Audits will be conducted 3x/week for 4 weeks and then 2x/month x</p> |                                                        |                            |



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| K 918                                                                                    | Continued From page 13<br>it was revealed by a review of available documentation that the facility was not running the emergency generator at or above 30 percent every month, and at the time of the survey could not provide documentation showing that an annual load bank test had been completed.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | K 918                                                                      | 2 months. Results will be shared with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 920<br>SS=E                                                                            | Electrical Equipment - Power Cords and Extens<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 | K 920                                                                      |                                                                                                                                                                                      | 11/29/24                   |                                                        |

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| K 920                                                                                    | Continued From page 14<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 10/23/2024 at 11:27 AM, it was revealed by observation that there was a coffee maker plugged into an extension cord in the kitchen manager's office.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery. | K 920                                                                      | The power cord was immediately unplugged and removed from the employee's office.<br><br>Office staff will be educated on K920 related to electrical equipment, specifically power cords and extension cords.<br><br>Administrator, or designee will audit all care center offices for unauthorized power strips and extension cords. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 930<br>SS=D                                                                            | Gas Equipment - Liquid Oxygen Equipment<br>CFR(s): NFPA 101<br><br>Gas Equipment - Liquid Oxygen Equipment<br>The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99).<br>11.7 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could                                                                                                                                                                                                                                                                                                                                            | K 930                                                                      | The oxygen tank was immediately removed from the egress corridor and placed back into the resident's room for usage.                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11/29/24                   |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245518</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                          | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 930                                                                                    | <p>Continued From page 15</p> <p>have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/23/2024 at 10:30 AM, it was revealed by observation that there was a liquid oxygen container being stored in the egress corridor near resident room 312.</p> <p>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery.</p> | K 930                                                                      | <p>Education will be conducted with staff to ensure staff know that liquid oxygen cannot be stored in corridors and must be stored properly in the oxygen storage room.</p> <p>Administrator, or designee will audits on care center hallways for oxygen storage in egress corridors. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                        |



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
January 22, 2025

Administrator  
Woodlake Healthcare And Rehabilitation Center  
8000 Bass Lake Road  
New Hope, MN 55428-3118

RE: CCN: 245518  
Cycle Start Date: October 25, 2024

Dear Administrator:

On December 11, 2024, we notified you a remedy was imposed. On December 9, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 20, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 25, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of December 11, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 25, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 20, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Orville L. Freeman Building | HRD 3A 3rd Floor  
Office: 651-201-4384  
Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)

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*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
November 7, 2024

Administrator  
St. Therese Home  
8000 Bass Lake Road  
New Hope, MN 55428-3118

RE: CCN: 245518  
Cycle Start Date: October 25, 2024

Dear Administrator:

On October 25, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

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

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St Therese Home  
November 7, 2024  
Page 2

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

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

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

## DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor  
St. Cloud B District Office  
Health Regulation Division  
Minnesota Department of Health  
4140 Thielman Lane  
Saint Cloud, Minnesota 56301-4557  
Email: [judy.loecken@state.mn.us](mailto:judy.loecken@state.mn.us)  
Office: (320) 223-7300 Mobile: (320) 241-7797

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

St Therese Home  
November 7, 2024  
Page 3

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 25, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 25, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

#### **INFORMAL DISPUTE RESOLUTION (IDR)**

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

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

#### **INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

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

St Therese Home  
November 7, 2024  
Page 4

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

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

Travis Z. Ahrens  
State Fire Safety Supervisor  
Health Care & Correctional Facilities  
MN Department of Public Safety-Fire Marshal Division  
445 Minnesota St., Suite 145  
St. Paul, MN 55101  
Email: [travis.ahrens@state.mn.us](mailto:travis.ahrens@state.mn.us)  
Web: [www.sfm.dps.mn.gov](http://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](mailto:holly.zahler@state.mn.us)



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

PRINTED: 12/09/2024  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245518</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                             |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/25/2024</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| E 000                                                                                    | Initial Comments<br><br>On 10/22/24 through 10/25/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance.<br><br>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.<br><br>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 025<br>SS=C                                                                            | Arrangement with Other Facilities<br>CFR(s): 483.73(b)(7)<br><br>§403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] |                                                                            |  | E 025                                                                                            |                                                                                                                          |                                                                    | 11/29/24                   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/16/2024

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.

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

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                            |                            |                                                                    |
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| E 025                                                                                    | <p>Continued From page 1</p> <p>*[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview and document review, the facility failed to develop arrangements with other facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. This had the potential to affect all 159 residents residing in the facility.</p> <p>Findings include:</p> | E 025                                                                      | <p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible</p> |                            |                                                                    |

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

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| E 025                                                                                    | <p>Continued From page 2</p> <p>Review of the facility's Emergency Preparedness (EP) plan identified the facility did not have any written agreements or contracted arrangements with other facilities to receive residents in the event of limitations or cessation of operation to maintain the continuity of services to facility residents.</p> <p>On 10/25/24 at 2:50 p.m., the administrator confirmed the facility did not have any valid agreements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. The administrator stated the facility should have prearranged agreements with other facilities to receive residents.</p> <p>The facility's Emergency Preparedness Committee policy, dated 2021, indicated the facility would establish agreements or contracts with local agencies and businesses to maintain continuity of care and provide contingencies and cooperative arrangements that may be necessary prior to, during, and after emergencies.</p> | E 025                                                                      | <p>allegation of compliance.</p> <p>The community has policies and procedures related to Emergency Preparedness and the requirement to establish agreements or contacts with local agencies and businesses to maintain the continuity of care and provide contingencies and arrangements in the event of an emergency.</p> <p>These policies have been reviewed and updated and remain current.</p> <p>The community has a completed transfer agreements.</p> <p>The administrator or designee will review the agreements at the next QAPI meeting. Emergency binder will be reviewed annually and ongoing as needed to ensure agreements will remain current. Administrator and/or designee will be responsible for oversight and monitoring. The results will be reviewed with the facility QAPI committee for further input and if the agreements satisfy the size and needs of our community. Any recommendations will be addressed.</p> |                            |                                                                    |
| E 039<br>SS=C                                                                            | <p>EP Testing Requirements<br/>CFR(s): 483.73(d)(2)</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | E 039                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 11/29/24                   |                                                                    |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245518</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/25/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b>                         |                            |                                                                    |
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| E 039                                                                                    | <p>Continued From page 3</p> <p>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br/>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br/>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br/>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br/>(B) A mock disaster drill; or<br/>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |

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| E 039                                                                                    | <p>Continued From page 4</p> <p>exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |

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| E 039                                                                                    | <p>Continued From page 5</p> <p>exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |

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| E 039                                                                                    | <p>Continued From page 6</p> <p>is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |

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| E 039                                                                                    | <p>Continued From page 7</p> <p>accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |



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| E 039                                                                                    | <p>Continued From page 8</p> <p>accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |

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| E 039                                                                                    | <p>Continued From page 9</p> <p>engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245518</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/25/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b>                         |                            |                                                                    |
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| E 039                                                                                    | <p>Continued From page 10</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain</p> | E 039                                                                      |                                                                                                                          |                            |                                                                    |

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| E 039                                                                                    | <p>Continued From page 11</p> <p>documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[ RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to conduct exercises to test their emergency preparedness (EP) plan at least twice per year, . This had the potential to affect all 159 residents who currently resided in the facility.</p> <p>Findings include:</p> <p>Review of the facility's EP plan identified the facility had not conducted an additional second exercise to test their EP plan that included a potential second full-scale exercise, a mock disaster drill, or an additional tabletop exercise, and analyze the facility's response to that additional exercise.</p> <p>On 10/25/24 at 2:50 p.m., the administrator confirmed there was no documentation to support</p> |                                                                            |  | E 039                                                                                            | <p>The community has policies and procedures related to Emergency Preparedness and the requirement to establish agreements or contacts with local agencies and businesses to maintain the continuity of care and provide contingencies and arrangements in the event of an emergency.</p> <p>These policies have been reviewed and updated and remain current.</p> <p>Table top exercise will be completed on 11/20/2024.</p> <p>Administrator and/or designee will be responsible for oversight and monitoring. Emergency binder will be reviewed</p> |                                                                    |                            |

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| E 039                                                                                    | Continued From page 12<br>an additional exercise had been performed in the<br>EP plan documentation. The administrator stated<br>the facility should have completed exercises to<br>test their EP plan at least twice per year.<br><br>The facility's Emergency Preparedness<br>Committee policy, dated 2021, indicated the<br>facility would ensure testing requirements were<br>completed as planned in accordance with<br>guidance.                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |  | E 039                                                                                            | annually and ongoing as needed to<br>ensure emergency exercises are<br>maintained per regulatory requirements.<br>The community has signed up for the<br>Metro Emergency Preparedness Coalition<br>email blasts and will stay connected with<br>the Coalition on ongoing table tops and/or<br>community wide exercises. The<br>administrator or designee will review and<br>share the tabletop with the facility QAPI<br>committee and will receive feedback<br>regarding emergency readiness. Any<br>recommendations will be addressed. |                                                                    |  |
| F 000                                                                                    | INITIAL COMMENTS<br><br>On 10/22/24 through 10/25/24, a standard<br>recertification survey was conducted at your<br>facility. A complaint investigation was also<br>conducted. Your facility was NOT in compliance<br>with the requirements of 42 CFR 483, Subpart B,<br>Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed with NO<br>deficiencies cited: H55189383C (MN107138);<br>H55189403C (MN103332); H55189404C<br>(MN104020); H55189405C (MN101729);<br>H55189408C (MN100829); H55189422C<br>(MN106452); H55189448C (MN102570);<br>H55189765C (107717)<br><br>AND<br><br>The following complaint was reviewed:<br>H55189409C (MN105723) with deficiencies cited<br>at F550, F677, and deficient practice was<br>identified related to incidental findings at F689.<br><br>The facility's plan of correction (POC) will serve |                                                                            |  | F 000                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                    |  |

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| F 000                                                                                    | Continued From page 13<br>as your allegation of compliance upon the<br>Departments acceptance. Because you are<br>enrolled in ePOC, your signature is not required<br>at the bottom of the first page of the CMS-2567<br>form. Your electronic submission of the POC will<br>be used as verification of compliance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | F 000                                                                      |                                                                                                                          |                            |                                                                    |
| F 550<br>SS=D                                                                            | <p>Upon receipt of an acceptable electronic POC, an<br/>onsite revisit of your facility may be conducted to<br/>validate substantial compliance with the<br/>regulations has been attained.</p> <p>Resident Rights/Exercise of Rights<br/>CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights.<br/>The resident has a right to a dignified existence,<br/>self-determination, and communication with and<br/>access to persons and services inside and<br/>outside the facility, including those specified in<br/>this section.</p> <p>§483.10(a)(1) A facility must treat each resident<br/>with respect and dignity and care for each<br/>resident in a manner and in an environment that<br/>promotes maintenance or enhancement of his or<br/>her quality of life, recognizing each resident's<br/>individuality. The facility must protect and<br/>promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal<br/>access to quality care regardless of diagnosis,<br/>severity of condition, or payment source. A facility<br/>must establish and maintain identical policies and<br/>practices regarding transfer, discharge, and the<br/>provision of services under the State plan for all<br/>residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights.</p> | F 550                                                                      |                                                                                                                          | 11/29/24                   |                                                                    |

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| F 550                                                                                    | <p>Continued From page 14</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to provide and maintain dignity for 1 of 1 residents (R106) reviewed for dignity.</p> <p>Findings Include:</p> <p>R106's quarterly minimum data set (MDS) dated 6/17/24, indicated a severely impaired cognition, diagnosis of dementia (a group of symptoms affecting memory, thinking and social abilities) and required extensive assistance for dressing, grooming and toileting.</p> <p>R106's care plan dated 7/21/24, indicated R106 required extensive assist of 1 staff for dressing and grooming. The care plan did not indicate if R106 preferred to wear her own clothes or a hospital type gown.</p> <p>On 10/22/24 at 3:26 p.m., R106 was in her room, sitting in her wheelchair wearing a white with blue</p> | F 550                                                                      | <p>Dignity has been provided and maintained for R106. She is dressed in appropriately fitting clothes daily and her hair is neat and clean.</p> <p>Residents residing at Woodlake have the potential to be affected. Dignity has been provided and maintained for all identified residents. Residents are dressed in appropriately fitting clothes daily and their hair is neat and clean.</p> <p>Nursing staff have been educated on the requirements to provide and maintain dignity to residents who are dependent on staff for ADLs. They have been educated to ensure residents are dressed daily in clothes that are clean and fit appropriately. They have been educated on providing hair care daily and as needed so residents appearance is neat, clean, and dignified.</p> |                            |                                                                    |

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| F 550                                                                                    | <p>Continued From page 15</p> <p>flowers hospital type gown. R106 did not have on any type of footwear. R106's hair was uncombed and had areas that appeared to be matted and other areas that stood up approximately 2 inches from her scalp.</p> <p>During observation and interview on 10/22/24 at 3:31 p.m. certified nursing assistant (CNA)-A assisted R106 to bed and stated she was familiar with R106 but didn't typically work with her during the day shift. CNA-A stated R106 was usually dressed in a gown but was unable to confirm if R106 preferred to be dressed in her own clothes.</p> <p>On 10/25/24 at 10:11 a.m. R106 was observed in bed wearing a white with blue flowered hospital type gown.</p> <p>On 10/25/24 at 11:48 a.m. R106 was observed in her wheelchair being pushed in the hallway in the direction of the dining room. R106 was wearing a white with blue flowered hospital gown and a pair of dark colored pant and yellow gripper socks. The hem on R106's pants was approximately 4 inches above her ankles. R106's hair was not combed.</p> <p>During interview on 10/25/24 at 10:41 a.m., CNA-B stated she was familiar with R106 and stated she liked to be dressed every day and frequently wore hospital gowns. CNA-B stated she knew how to take care of R106 as her cares were listed on a care sheet taped to the inside of the closet door. CNA-B was unable to indicate on the care sheet if R106 preferred to wear her own clothes or a hospital gown.</p> <p>During interview on 10/25/24 at 11:01 a.m., CNA-C stated she was familiar with R106 and</p> | F 550                                                                      | <p>Audits to ensure dignity is being provided and maintained for the residents including but not limited to ensuring they are dressed in clean appropriately fitting clothes and hair care is completed to maintain a dignified appearance will be completed by DON/designee. The audit schedule will be as follows: 4 residents 3 x per week x 4 weeks, then 3 residents 3 x per week x 3 weeks, then 2 residents 2 x per week x 2 weeks then, 1 resident weekly x 1 month. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                                    |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b>                         |                            |                                                                    |
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| F 550                                                                                    | <p>Continued From page 16</p> <p>had assisted her to get ready for the day that morning. CNA-C stated R106 required assistance to get dressed every day as well as help with her oral care and brushing her hair. CNA-C stated she did not know if R106 preferred her own clothes or a hospital gown, nor did she know where to find that information.</p> <p>During interview on 10/25/24 at 1:11 p.m., R106's family member (FM)-A stated R106 preferred to wear her own clothes every day and took great pride in her appearance. FM-A went on to say at a recent appointment R106 had been dressed in pants that were too short, was not wearing a bra under her shirt and her hair was messy. FM-A stated R106 would never have left her house looking like that. She continued to say R106 had many nice matching tops and bottoms but was rarely dressed in anything except a hospital gown. She stated her mom used to always try to look nice and it would make her sad to not be dressed nice with her hair neat.</p> <p>During interview on 10/25/24, at 11:19 a.m., the director of nursing (DON) stated R106 required assistance with getting dressed, oral care, grooming and toileting. She stated staff could look at R106's care plan located inside her closet door to see preferences for R106. DON stated she expected staff to assist residents to wear clean, neat clothing and to comb their hair to help residents to feel good about their appearance. DON stated it was important for residents to feel good about how they looked, and it was a matter of dignity for themselves. DON stated residents emotional well being could be negatively affected if they didn't feel good about their physical appearance.</p> | F 550                                                                      |                                                                                                                          |                            |                                                                    |

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| F 550                                                                                    | Continued From page 17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | F 550                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          |                                                                    |
| F 554<br>SS=D                                                                            | <p>Facility policy titled Promoting/Maintaining resident dignity, dated October 2022 indicated the following: The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences. Groom and dress residents according to resident preferences.</p> <p>Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)</p> <p>§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:</p> <p>Based on observation, interview and document review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 1 of 1 resident (R423) reviewed.</p> <p>Findings include:</p> <p>R423's annual Minimum Data Set (MDS) dated 9/9/24, identified R423's cognition as moderately impaired and needed assistance with of one staff with activities of daily living (ADL's).</p> <p>During an observation on 10/24/24 at 7:45 a.m., R423 was laying in her bed with lights on. R423 had a tube of Asper Crème (treats muscle and joint pain), a container of petroleum jelly, and two bottles of Nystatin powder in the yellow bin next to the nightstand and unsecured. R423 stated the nursing assistant (NA) "put that on for me".</p> <p>During medical record review on 10/24/24, the</p> | F 554                                                                      | <p>Resident #423 continues to not be appropriate to self-administer medications. The Asper creme, petroleum jelly, and nystatin topical powder bottles have been removed from her room. The resident's medications are only being administered by nurses or TMAs.</p> <p>Residents residing at Woodlake have the potential to be affected. All residents have been reviewed. Residents identified as self-administering medications and keeping at bedside have a current self-medication assessment and order. They have a secure location to store the medications, and the medications are not expired. Medication administration is only being conducted by nurses or TMAs.</p> <p>Nursing staff have been educated that only residents with orders and assessments indicating they are safe to</p> | 11/29/24 |                                                                    |

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| F 554                                                                                    | <p>Continued From page 18</p> <p>medical record lacked evidence of an assessment for self-administering medications (SAM) being completed. The medical record lacked evidence of a physician order for a SAM.</p> <p>During an interview on 10/24/24 at 9:33 a.m., NA-A stated R423 requested the contents of the yellow tube of crème on her shoulders for pain and "I [NA-A] did on 10/18/24 around supper time".</p> <p>During a tour of R423 room on 10/24/24 at 1:26 p.m. nurse manager (NM)-A revealed a five-ounce Asper crème tube with 10% trolamine salicylate that expired 2/24. A 13-ounce petroleum jelly container and two bottles of nystatin topical powder 30 grams each which were low in content. One had expired 6/16/24 and the other 2/19/24.</p> <p>During an interview on 10/24/24 at 1:56 p.m., NM-A stated R423 did not have a SAM order and no assessment to SAM. NM-A stated R423 could not apply the creams and powder by themselves. NM-A stated R423 was not to have medications in her room without an order. NM-A stated she did not know the medications were in the room. NM-A stated the NAs were not trained to put on topical creams and powders.</p> <p>During an interview on 10/24/24 at 2:22 p.m., the director of nursing (DON) stated the NAs cannot put on creams and powders, only the nurses.</p> <p>The facility policy Self Administration of Medications dated 8/24, indicated a resident may only self-administer medications after the facility's has evaluated the resident and determined which medications may be self-administered safely. The</p> | F 554                                                                      | <p>self-administer medications and store at bedside are allowed to have medications left in their rooms. They were educated that medications must be stowed in a secured location and must not be expired. They have been educated that only a Nurse or a TMA may administer or apply medications, including but not limited to topical over-the-counter medication or creams, ointments, powders, or lotions.</p> <p>Audits will be completed to ensure only nurses or TMAs are administering medications. Additionally, the audit will include monitoring of residents to ensure that only residents who have been assessed as safe to administer medications and stow at the bedside will have medications secured in their room. These medications will be audited to ensure they are not expired.</p> <p>Audits will be completed by DON/designee. The audit schedule will be as follows: 4 residents 3 x per week x 4 weeks, then 3 residents 3 x per week x 3 weeks, then 2 residents 2 x per week x 2 weeks then, 1 resident weekly x 1 month. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                                    |

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| F 554                                                                                    | Continued From page 19<br>nursing staff is responsible for proper rotation of<br>bedside stock and removal of expired<br>medications.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | F 554                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                            |                                                                    |
| F 677<br>SS=D                                                                            | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry<br>out activities of daily living receives the necessary<br>services to maintain good nutrition, grooming, and<br>personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on observation, interview and record<br>review, the facility failed to ensure assistance with<br>dressing and grooming for 1 of 3 residents<br>(R106) reviewed for activities of daily living (ADL)<br>care provided for dependent residents.<br><br>Finding include:<br><br>R106's quarterly Minimum Data Set (MDS) dated<br>6/17/24, indicated severely impaired cognition,<br>diagnosis of dementia (a group of symptoms<br>affecting memory, thinking and social abilities)<br>and required extensive assistance for dressing,<br>grooming, bathing, oral cares and toileting. The<br>MDS indicated R106 did not reject or refuse<br>cares.<br><br>R106's care plan dated 7/21/24, indicated R106<br>had an ADL deficit related to dementia and<br>required extensive assist of 1 staff for dressing,<br>grooming, bathing, and elimination. The care plan<br>indicated R106 would receive the necessary<br>assistance with all ADL's. The care plan also<br>indicated R106 did not have any natural teeth and<br>instructed staff to assist with denture placement<br>every AM and removal every PM. The care plan | F 677                                                                      | Resident's R106 has had hand hygiene<br>completed. The resident's wig has been<br>combed and is neat and clean. The<br>resident has had oral care completed and<br>assistance with denture placement.<br><br>Residents residing at Woodlake who are<br>dependent on staff for ADLs have the<br>potential to be affected. ADL assistance<br>has been provided to identified residents<br>per their plan of care and Kardex<br>instructions. All residents hair has been<br>combed and is neat and clean. All<br>residents requiring assistance with hand<br>hygiene, oral care, and placement of<br>dentures have had these tasks<br>completed.<br><br>Nursing staff have been educated on<br>following the plan of care and Kardex<br>instruction when caring for residents.<br>They have been taught where to find this<br>information. They have been educated on<br>the requirement of providing residents<br>assistance with grooming tasks, including<br>but not limited to combing hair, assisting | 11/29/24                   |                                                                    |

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| F 677                                                                                    | <p>Continued From page 20</p> <p>instructed staff to encourage and assist R106 to perform proper hand hygiene on hands and nails before snacks and meals. The care plan did not indicate R106 preference to wear her own clothes or hospital type gowns.</p> <p>On 10/22/24 at 3:26 p.m., R106 was sitting in her room, in a wheelchair wearing a white with blue flowered hospital type gown. R106 did not have on any footwear. R106's hair was messy, uncombed with areas that were matted and others that stood up approximately 2 inches from her scalp. Certified nursing assistants (CNA)-A and D entered R106's room and transferred R106 from her wheelchair to bed using a ceiling lift. Upon completion of transfer CNA-A gave an opened package of chocolate frosted cookies to R106. R106 immediately began taking cookies out of the package and put them into her mouth. CNA-A did not assist R106 with hand hygiene.</p> <p>During interview on 10/22/24 at 3:31 p.m., CNA-A stated she was familiar with R106, her cares, and required assistance with dressing and toileting. CNA-A stated she knew how to care for R106 by looking at the care plan taped to the inside of the door of the closet. CNA-A pointed to the care plan and identified R106's cares were dressing, personal grooming, denture care and toileting. CNA-A stated R106 didn't have her dentures in at that time and confirmed she did not provide hand hygiene prior to giving R106 the opened package of cookies.</p> <p>On 10/25/24 at 10:11 a.m., R106 was lying in her bed wearing a white with blue flowers hospital type gown. R106's hair was messy, uncombed, and an opened package of chocolate frosted cookies was on the bed next to residents left</p> | F 677                                                                      | <p>with oral care, and placing dentures if applicable.</p> <p>Audits will be completed to ensure ADL assistance is occurring including but not limited to hand hygiene, hair care, oral hygiene, and assistance with denture placement by DON/designee. The audit schedule will be as follows: 4 residents 3 x per week x 4 weeks, then 3 residents 3 x per week x 3 weeks, then 2 residents 2 x per week x 2 weeks then, 1 resident weekly x 1 month. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                                    |

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| F 677                                                                                    | <p>Continued From page 21 hand.</p> <p>During interview on 10/25/24 at 11:01 a.m., CNA-C stated she was familiar with R106's care and frequently assisted her. CNA-C stated she had assisted R106 to get ready earlier that day. CNA-C stated R106 needed assistance getting dressed every day as well as help with her oral care and brushing her hair. CNA-C stated she did not know if R106 preferred her own clothes or a hospital gown, nor did she know where to find that information. CNA-C stated she had not assist R106 with hair care or denture/oral cares during morning cares.</p> <p>On 10/25/24 at 11:48 a.m., R106 was in her wheelchair being pushed towards the dining room by an unidentified staff member. R106 was wearing a white with blue flowered hospital gown and a pair of dark colored pants with yellow gripper socks. The hem on R106's pants was approximately 4 inches above her ankles. R106's hair was messy and uncombed.</p> <p>During interview on 10/25/24 at 1:11 p.m., family member (FM)-A stated R106 preferred to wear her own clothes every day and took great pride in her appearance. FM-A stated R106 always tried to look nice, and it would make her sad to not be dressed nice with her hair neat.</p> <p>During interview on 10/25/24 at 11:19 a.m., the director of nursing (DON) stated R106 required assistance with getting dressed, oral care, grooming and toileting. Staff should look at the care plan located inside the closet door to see preferences for R106. DON confirmed R106 did not prefer to wear hospital gowns. DON stated she expected staff to assist residents to wear</p> |                                                                            |  | F 677                                                                                            |                                                                                                                          |                                                                    |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| F 677                                                                                    | Continued From page 22<br>clean, neat clothing and to comb their hair to help residents to feel good about their appearance. DON stated she expected staff to assist every resident with all necessary ADL's. DON stated assisting residents with ADL cares was beneficial to a residents physical and emotional health.<br><br>Facility policy titled Activities of daily living (ADL's) dated January 2023 indicated the facility will provide care and services for activities of daily living to include, bathing, dressing, grooming and oral care. The policy further indicated any resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. |                                                                            |  | F 677                                                                                            |                                                                                                                                                                                                                                                                                                     |                                                                    |                            |
| F 689<br>SS=D                                                                            | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure care plan interventions were being utilized for 1 of 2 residents (R106) reviewed for safety.<br><br>Findings include:<br><br>R106's quarterly Minimum Data Set (MDS) dated 6/17/24, indicated severely impaired cognition,                                           |                                                                            |  | F 689                                                                                            | The resident's R106 call light has been placed within her reach. The call light has a clip attached to it.<br><br>Residents residing at Woodlake have the potential to be affected. All residents have call lights placed within reach. All call lights have clips attached so they can be secured. |                                                                    | 11/29/24                   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                                                                    |
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| F 689                                                                                    | <p>Continued From page 23</p> <p>diagnosis of dementia (a group of symptoms affecting memory, thinking and social abilities) and required extensive assistance for dressing, grooming and toileting.</p> <p>R106's care plan revised on 9/15/24, indicated R106 was at risk for falls and had a history of falls. Interventions included staff assistance by placing the call light where the resident can reach it before exiting the room each time, and ensure all personal belongings are within reach for the resident.</p> <p>During continuous observation on 10/25/24 beginning at 10:11 a.m. through 11:06 a.m., R106 was lying in her bed. A white call light with a red button to push for assistance was noted to be lying on the floor under the bedside table approximately 2 feet away, outside of R106's reach. There was no clip to attach the call light noted on the call light cord. No other call light was noted in the room.</p> <p>During interview on 10/25/24 at 10:41 a.m., certified nursing assistant (CNA)-B stated R106 was functionally able to use the call light if she needed staff assistance. CNA-B stated R106 had both a soft touch call light and one with a button to push for assistance. CNA-B stated R106 would primarily use the white call light with the red button because she was most familiar with that type. CNA-B stated she would clip the call light to the blankets or the wheelchair to keep it within reach of R106.</p> <p>During interview on 10/25/24 at 11:01 a.m. CNA-C entered R106's room and confirmed R106's white call light was lying on the floor outside of R106's reach, and there was no other</p> | F 689                                                                      | <p>Staff have been educated that call lights are to be within reach of the resident and secured to ensure placement if needed.</p> <p>Audits will be completed by the Administrator/Designee to ensure call lights are within reach of residents and that there are clips attached to them to use to secure if needed. The audit schedule will be as follows: 4 residents 3 x per week x 4 weeks, then 3 residents 3 x per week x 3 weeks, then 2 residents 2 x per week x 2 weeks then, 1 resident weekly x 1 month. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                                    |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b> |                                                                                                                          |                                                                    |                            |
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| F 689                                                                                    | <p>Continued From page 24</p> <p>call light available within reach of R106. CNA-C stated R106 was functionally able to use her call light appropriately to summon for help if needed. CNA-C stated she had clipped the call light the blankets on the bed before her break and didn't know how it got on the floor. CNA-C stated without the call light R106 would have to yell out to get help. CNA-C stated she was unsure if staff in another room would be able to hear R106 if she was calling out.</p> <p>During interview on 10/25/24 at 11:19 a.m., the director of nursing (DON) stated all resident should have a call light or device within their reach to summon staff for assistance whenever staff left the room. DON stated she expected staff to either hand the call light directly to the resident or clip it the residents clothing or blankets. DON stated this was extremely important for residents' safety and for residents to be able to communicate their need of assistance to staff.</p> <p>Facility policy title Call lights: accessibility and timely response dated January 2023 indicated each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call light system. Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.</p> |                                                                            |  | F 689                                                                                            |                                                                                                                          |                                                                    |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                               |                            |                                                        |
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| K 000                                                                                    | <p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/23/2024. At the time of this survey, St Therese Home (name changed to Woodlake At New Hope) 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.</p> <p>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.</p> <p>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.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p> | K 000                                                                      |                                                                                                                          |                            |                                                        |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/16/2024

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                                                                                    | <p>Continued From page 1</p> <p>Healthcare Fire Inspections<br/>State Fire Marshal Division<br/>445 Minnesota St., Suite 145<br/>St. Paul, MN 55101-5145, OR</p> <p>By email to:<br/>FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH<br/>DEFICIENCY MUST INCLUDE ALL OF THE<br/>FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> <li>1. A detailed description of the corrective action<br/>taken or planned to correct the deficiency.</li> <li>2. Address the measures that will be put in<br/>place to ensure the deficiency does not reoccur.</li> <li>3. Indicate how the facility plans to monitor<br/>future performance to ensure solutions are<br/>sustained.</li> <li>4. Identify who is responsible for the corrective<br/>actions and monitoring of compliance.</li> <li>5. The actual or proposed date for completion of<br/>the remedy.</li> </ol> <p>St Therese Home (name changed to Woodlake<br/>At New Hope) is a 3-story building with no<br/>basement. The building was constructed at four<br/>different times. The original building was<br/>constructed in 1968 and was determined to be of<br/>Type I (332) construction. In 1973, an addition<br/>was constructed to the 3rd floor that was<br/>determined to be of Type II (111) construction. In<br/>1999, an addition was constructed to the west<br/>side of the 1st floor that was determined to be of</p> | K 000                                                                      |                                                                                                                          |                            |                                                        |

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| K 000                                                                                    | Continued From page 2<br><br>Type I (332). Another addition was constructed in 2003 to the 2nd and 3rd floor that was determined to be of Type I (332). Because the 3rd floor was determined to be Type II (111), the building was downgraded to Type II (111). Being that the construction type is allowed for an existing building of this height, the building is surveyed as one building. The building is fully automatic fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification.<br><br>The facility has a capacity of 188 beds and had a census of 160 at the time of the survey.     | K 000                                                                      |                                                                                                                                                      |                            |                                                        |
| K 211<br>SS=E                                                                            | The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:<br><br>Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain egress paths per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. These deficient | K 211                                                                      | Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also | 11/29/24                   |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |                                                        |
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| K 211                                                                                    | Continued From page 3<br>findings could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 10/23/2024 at 11:37 AM, it was revealed by observation that a patient lift was blocking the emergency exit door near resident room 237.<br><br>2. On 10/23/2024 at 12:05 PM, it was revealed by observation that there was a desk with a laptop and chair in the egress corridor near resident room 156.<br><br>3. On 10/23/2024 at 12:14 PM, it was revealed by observation that a bed, boxes and a chair were being stored in the egress corridor outside of the boiler room.<br><br>4. On 10/23/2024 at 12:22 PM, it was revealed by observation that a pallet, microwave, recliner chair, and a fan were being stored in the egress corridor near the loading dock.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified these deficient findings at the time of discovery. | K 211                                                                      | not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br><br>Findings 1-4 items were immediately moved or cleaned out of the path of egress as areas of concern were identified.<br><br>Education will be provided to staff on blocking emergency exits, furniture and storage in the egress corridor in resident care units, in the loading dock, and in maintenance hallways.<br><br>Administrator, Plant Operations Director, or designee will audit emergency exits and egress corridors for compliance as it relates to blockage and storage in the means of exit and egress. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 321<br>SS=D                                                                            | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | K 321                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11/29/24                   |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                            |                            |                                                        |
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| K 321                                                                                    | <p>Continued From page 4</p> <p>system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler<br/>Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms<br/>b. Laundries (larger than 100 square feet)<br/>c. Repair, Maintenance, and Paint Shops<br/>d. Soiled Linen Rooms (exceeding 64 gallons)<br/>e. Trash Collection Rooms (exceeding 64 gallons)<br/>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br/>g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/23/2024 at 11:45 AM, it was revealed by observation that the door to the soiled utility room</p> | K 321                                                                      | <p>Identified material stored in the strike plate was immediately removed and the door positively latched.</p> <p>Education will be provided to staff related to the requirement of maintaining hazardous rooms per the life safety code. Education will specifically call out examples of stuffing garbage bags, paper towel, or any other item into the door strike plates that prevents hazardous materials from being locked.</p> |                            |                                                        |

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| K 321                                                                                    | Continued From page 5<br>106 had a trash bag stuffed into the strike plate causing the door to not positively latch.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | K 321                                                                      | Administrator, Plant Operations Director, or designee will audit all hazardous materials storage rooms to ensure the door positively latches and nothing is stored inside the door's strike plate. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 324<br>SS=E                                                                            | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 | K 324                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 11/29/24                   |                                                        |

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| K 324                                                                                    | <p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. These deficient findings could have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>1. On 10/23/2024 at 11:52 AM, it was revealed by observation that the residential stove located in the first floor west resident lounge does not have a locked switch, or a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action.</p> <p>2. On 10/23/2024 at 12:10 PM, it was revealed by observation that the residential stove located in the first floor east resident lounge does not have a locked switch, or a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action.</p> <p>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified these deficient findings at the time of discovery.</p> | K 324                                                                      | <p>On findings 1-2, during the survey stoves were immediately turned off.</p> <p>The electrical power cords were removed from the stove to prevent any future use. Staff and residents will be notified that the ovens are for decorative purposes only moving forward and will no longer function unless requirements are met by NFPA 101 (2012 edition) and Life Safety Code requirements as it relates to cooking facilities.</p> <p>The Administrator, Plant Operations Director, or designee is responsible for ensuring the stove lines are turned off and no longer functional. Findings and solutions will be shared with the facility QAPI committee. Discrepancies will be addressed and corrected.</p> |                            |                                                        |



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| K 345<br>SS=D                                                                            | <p>Fire Alarm System - Testing and Maintenance<br/>CFR(s): NFPA 101</p> <p>Fire Alarm System - Testing and Maintenance<br/>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br/>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on observation and staff interview, the facility failed to maintain access to fire alarm pull stations per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3 and 9.6.2.7, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 17.14.5. This deficient finding could have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/23/2024 at 11:37 AM, it was revealed by observation that the fire alarm pull station near resident room 237 was blocked by a patient lift being left in front of it.</p> <p>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery.</p> | K 345                                                                      | <p>Findings noted during the survey were immediately moved from blocking the fire pull station.</p> <p>Education will be provided to staff on blocking fire pull stations and fire extinguishers with equipment in accordance with Fire Alarm System Testing and Maintenance standards of the Life Safety Code.</p> <p>Administrator, Plant Operations Director, or designee will audit fire alarm pull stations and fire extinguisher for blockage. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> | 11/29/24                   |                                                        |
| K 355<br>SS=D                                                                            | <p>Portable Fire Extinguishers<br/>CFR(s): NFPA 101</p> <p>Portable Fire Extinguishers<br/>Portable fire extinguishers are selected, installed,</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | K 355                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11/29/24                   |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD</b><br><b>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                            |                                                        |
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| K 355                                                                                    | <p>Continued From page 8</p> <p>inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br/>18.3.5.12, 19.3.5.12, NFPA 10</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, a review of available documentation, and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/23/2024 at 11:58 AM, it was revealed by observation that the fire extinguisher located in the elevator mechanical room on the first floor had the last annual maintenance completed in August of 2023.</p> <p>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery.</p> | K 355                                                                      | <p>Plant Operations Director contacted Summit Fire to come out to the community to inspect the un-marked fire extinguisher noted during the survey. The non-inspected portable fire extinguisher was removed and replaced with one that is compliant.</p> <p>An audit of portable fire extinguishers in the community to be completed to ensure other fire extinguishers have been maintained appropriately.</p> <p>Administrator, Plant Operations Director, or designee will be responsible for auditing and monitoring. Audits will be monthly x 2 months. Plant operations director, or designee will maintain a list of all fire extinguishers in the community to ensure the vendor does not miss any portable fire extinguishers in the future. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                        |
| K 363<br>SS=E                                                                            | <p>Corridor - Doors</p> <p>CFR(s): NFPA 101</p> <p>Corridor - Doors</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | K 363                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11/29/24                   |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245518</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                              |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                               |                            |                                                        |
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| K 363                                                                                    | <p>Continued From page 9</p> <p>hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section</p> | K 363                                                                      | <p>All objects propping doors open that were identified in points 1-3 during the survey were removed immediately.</p>    |                            |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                            |                                                        |
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| K 363                                                                                    | Continued From page 10<br>19.3.6.3.10. These deficient findings could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 10/23/2024 at 11:11 AM, it was revealed by observation that the door to office 364A conference room was held open with a trash can.<br><br>2. On 10/23/2024 at 11:12 AM, it was revealed by observation that the door to resident room 363 was being held open with a chair.<br><br>3. On 10/23/2024 at 11:43 AM, it was revealed by observation the door to office 106 was being held open with a block of wood.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified these deficient findings at the time of discovery. | K 363                                                                      | Education will be provided to staff on the requirements of Corridor-Doors as outlined in K363. The education will be specifically surrounded by doors being propped open with objects.<br><br>Administrator, Plant Operations Director, or designee will audit corridor doors being propped open with any sort of object. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 511<br>SS=D                                                                            | Utilities - Gas and Electric<br>CFR(s): NFPA 101<br><br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br><br>This REQUIREMENT is not met as evidenced                                                                                                                                                                                                                                                                                                                                          | K 511                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 11/29/24                   |                                                        |

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| K 511                                                                                    | Continued From page 11<br>by:<br>Based on observation and staff interview, the facility failed to maintain the electrical system per NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and NFPA 70 (2011 edition), Life Safety Code, section 314.25. These deficient findings could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 10/23/2024 at 10:28 AM, it was revealed by observation that there was an open electrical junction box above the ceiling near office 301 Director of Social Services.<br><br>2. On 10/23/2024 at 11:00 AM, it was revealed by observation that the electrical breaker panel near resident room 327 was not locked.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified these deficient findings at the time of discovery. | K 511                                                                      | All open electrical junction boxes and breaker panels were secured and closed upon findings during the survey.<br><br>Education will be provided to maintenance staff on the requirements of electrical junction boxes and electrical breaker panels being secured and locked.<br><br>Administrator, Plant Operations Director, or designee will audit on breaker boxes and electrical junction boxes to ensure they are properly secured and locked. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 918<br>SS=F                                                                            | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance                                                                                                                                                                                                                                                                                                                                                                                                                      | K 918                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 11/29/24                   |                                                        |

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| K 918                                                                                    | <p>Continued From page 12</p> <p>with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2 and 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/23/2024 between 09:15 AM and 01:00 PM,</p> | K 918                                                                      | <p>Plant Operations Director called Allied and scheduled the annual load bank test.</p> <p>Load bank test was completed on 11/6/2024 from 9 am - 2 pm. Report was sent on 11/11/2024 and put in the binder.</p> <p>Administrator, Plant Operations Director, or designee will audit the community's life safety binder to ensure all necessary documentation and tasks have been completed. Audits will be conducted 3x/week for 4 weeks and then 2x/month x</p> |                            |                                                        |

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| K 918                                                                                    | Continued From page 13<br><br>it was revealed by a review of available documentation that the facility was not running the emergency generator at or above 30 percent every month, and at the time of the survey could not provide documentation showing that an annual load bank test had been completed.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | K 918                                                                      | 2 months. Results will be shared with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 920<br>SS=E                                                                            | Electrical Equipment - Power Cords and Extens<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 | K 920                                                                      |                                                                                                                                                                                      | 11/29/24                   |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 920                                                                                    | Continued From page 14<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 10/23/2024 at 11:27 AM, it was revealed by observation that there was a coffee maker plugged into an extension cord in the kitchen manager's office.<br><br>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery. | K 920                                                                      | The power cord was immediately unplugged and removed from the employee's office.<br><br>Office staff will be educated on K920 related to electrical equipment, specifically power cords and extension cords.<br><br>Administrator, or designee will audit all care center offices for unauthorized power strips and extension cords. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected. |                            |                                                        |
| K 930<br>SS=D                                                                            | Gas Equipment - Liquid Oxygen Equipment<br>CFR(s): NFPA 101<br><br>Gas Equipment - Liquid Oxygen Equipment<br>The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99).<br>11.7 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could                                                                                                                                                                                                                                                                                                                                            | K 930                                                                      | The oxygen tank was immediately removed from the egress corridor and placed back into the resident's room for usage.                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11/29/24                   |                                                        |



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

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245518</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAKE HEALTHCARE AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>8000 BASS LAKE ROAD<br/>NEW HOPE, MN 55428</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                          | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 930                                                                                    | <p>Continued From page 15</p> <p>have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/23/2024 at 10:30 AM, it was revealed by observation that there was a liquid oxygen container being stored in the egress corridor near resident room 312.</p> <p>An interview with the Executive Director, Healthcare Administrator, and the Director of Plant Operations verified this deficient finding at the time of discovery.</p> | K 930                                                                      | <p>Education will be conducted with staff to ensure staff know that liquid oxygen cannot be stored in corridors and must be stored properly in the oxygen storage room.</p> <p>Administrator, or designee will audits on care center hallways for oxygen storage in egress corridors. Audits will be conducted 3x/week for 4 weeks and then 2x/month x 2 months. Results will be reviewed with the facility QAPI committee for input in the need to increase, decrease, or discontinue audits. Discrepancies will be addressed and corrected.</p> |                            |                                                        |