

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 28, 2023

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

RE: CCN: 245320

Cycle Start Date: June 1, 2023

Dear Administrator:

On June 1, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by September 1, 2023 (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 December 1, 2023 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal Health Care/Corrections Supervisor — Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145

Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumala Fiske-Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 28, 2023

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

Re: State Nursing Home Licensing Orders

Event ID: 012011

Dear Administrator:

The above facility was surveyed on May 30, 2023 through June 1, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us

Office/Mobile: (651) 249-1724

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumala Fiske Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 07/11/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245320	B. WING		C 06/01/2023	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2020	
WOODLY	'N HEIGHTS HEALTH	CARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION	
E 000	Initial Comments		E 00	00		
	with Appendix Z, the Requirements, was recertification surve	23, a survey for compliance e Emergency Preparedness completed during a standard by. Woodlyn Heights was found to be in compliance its.				
F 000	signature is not required page of the CMS-25 correction is required acknowledge receiption.	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents.	F 00	00		
	survey was conducted. Minnesota Department addition, multiple completed. Woodly was found not in correquirements of 42	23, a standard recertification ted by surveyors from the nent of Health (MDH). In amplaint investigations were n Heights Healthcare Center mpliance with the CFR 483, Subpart B, the ong Term Care Facilities.				
	The following comp the survey:	laints were reviewed during				
	F676, F804, and F9 H53202432C (MN8	6824); deficiencies issued at 921. 97567) 97589); deficiency issued at				
_ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE	

Electronically Signed

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

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	` '	E SURVEY IPLETED
		245320	B. WING			C 01/2023
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
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F 645	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the form. Your electronic be used as verificate receipt of an accept onsite revisit of you validate that substate regulations has been PASARR Screening CFR(s): 483.20(k) (1) Section (1) Mental disorder at (1) of this section, unauthority has determind the level of services and (1) If the individual services, whether the specialized services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability authority has determined by a personal services (1) Intellectual disability (1) Intellectual disability (1) Intellectual disability (1) Intellectual disa	f correction (POC) will serve f compliance upon the stance. Because you are our signature is not required first page of the CMS-2567 c submission of the POC will ion of compliance. Upon table electronic POC, an are facility may be conducted to intial compliance with the en attained. If for MD & ID (1)-(3) ission Screening for ental disorder and individuals ability. In sing facility must not admit, on 1989, any new residents with: as defined in paragraph (k)(3) in less the State mental health in lined, based on an all and mental evaluation son or entity other than the authority, prior to admission, of the physical and mental evidual, the individual requires a provided by a nursing facility; requires such level of the individual requires				7/6/23

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '		COMPLETED	
		245320	B. WING		06/0	01/2023
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F 645	the level of services and (B) If the individual services, whether the specialized services §483.20(k)(2) Excessection—(i) The preadmission paragraph(k)(1) of for determinations it to a nursing facility being admitted to the transferred for care (ii) The State may oppreadmission screet paragraph (k)(1) of to a nursing facility (A) Who is admitted hospital after received hospital, (B) Who requires not condition for which the hospital, and (C) Whose attending before admission to is likely to require left facility services. §483.20(k)(3) Definition of the individual is condition of the individual is condition of the individual is condition.	vidual, the individual requires is provided by a nursing facility; requires such level of the individual requires is for intellectual disability. ptions. For purposes of this in screening program under this section need not provide in the case of the readmission of an individual who, after the nursing facility, was in a hospital. Schoose not to apply the ening program under this section to the admission of an individual did to the facility directly from a ring acute inpatient care at the the individual received care in the graphysician has certified, of the facility that the individual ess than 30 days of nursing dition. For purposes of this onsidered to have a mental dual has a serious mental	F	545		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		(X3) DATE SURVE COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
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F 645	described in 435.1 This REQUIREME by: Based on interviev	age 3 a related condition as 010 of this chapter. ENT is not met as evidenced w and document review, the sure a Level I Pre-Admission	F 645			
	Screening (PAS) a Pre-Admission Scr (PASARR) were comedical record, an continuity of care v	and, if needed, a Level II reening and Resident Review ompleted, retained in the did readily available to ensure with mental health needs for ts (R48) reviewed for PASARR.		Woodlyn Heights Senior Living den violated any federal or state regulat Accordingly, this plan of correction not constitute an admission or agre by the provider to the accuracy of the facts alleged or conclusions set for the statement of deficiencies. The provider to the provider to the statement of deficiencies.	tions. does ement ne th in olan of cuted	
	4/19/23, indicated had several medic major depressive of (mental illness charswings). However, have Alzheimer's of	Minimum Data Set (MDS), dated R48 was cognitively intact and al diagnoses including anxiety, disorder, and bipolar disorder aracterized by extreme mood the MDS indicated R48 did not disease (a brain disorder that emory and thinking skills) or		solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes an correlation with the most recently completed or accomplished correct action and do not correspond chronologically to the date the facili maintains it is in compliance with the requirements of participation, or the corrective action was necessary.	ive ty ie	
	indicated R48's culpresent upon admit The listing lacked at R48's initial Pre-Adresults, dated 4/5/2 hospitalized with a nursing home with listed as "30-60 da	gnosis listing, printed 6/1/23, rrent medical diagnoses were ission to the facility on 4/13/23. any diagnosis of dementia. dmission Screening (PAS) 23, indicated R48 was nticipated admission to a an anticipated length of stay sys". from Senior Linkage Line,		1. In continuing compliance with F 645, PASARR Screening for MD Woodlyn Heights Senior Living correct the deficiency by ensuring R48 fina PASARR was in the medical record 07/06/2023. All resident PASARRs reviewed to ensure accurate compl on 07/06/2023 by the Executive Dir 2. To correct the deficiency and to the problem does not recur the Soc Workers and Medical Records were	rected I I on were etion ector. ensure	
	dated 4/5/23, indic	ated "The Senior Linkage Line to the county/managed care		educated on the PASARR requirem	nents	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245320	B. WING _) 1/2023
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
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F 645	Continued From pa	ge 4	F 64	5		
	until the lead agend nursing facility." The	cessing. The PAS is not final by sends documentation to the letter went on to list a lead number for the facility to follow		The Executive Director and/or designable will audit 3 resident PASARRs week 4 weeks, 2 resident PASARRs week 4 weeks, 1 resident PASARR week weeks, and then randomly to ensure continued compliance.	kly for kly for ly for 4	
	lacked evidence a freceived and/or eva	inal determination had been aluated by the county or gram as directed by the PAS		3. As part of Woodlyn Heights Senic Living ongoing commitment to quali assurance, the Executive Director a designee will report identified conce through the community's QA Proces	ty and/or erns	
	MRC stated the PA most recent admiss when she received	on 5/31/23 at 11:02 a.m., the S dated 4/5/23 was for R48's sion. The MRC further stated the PAS, she scanned it into d not follow up with the county ed.				
	administrator stated	on 6/1/23 at 9:25 a.m., the dit was the medical records onsibility to ensure the PAS followed up on.				
	requested but not re	ng (ADLs)/Mntn Abilities	F 67	6		7/6/23
	resident's needs and provide the necessal ensure that a resident daily living do not did of the individual's class	on the comprehensive sident and consistent with the ad choices, the facility must ary care and services to ent's abilities in activities of iminish unless circumstances linical condition demonstrate in was unavoidable. This ensuring that:				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII	IPLE CONSTRUCTION NG	COMPLETED		
		245320	B. WING _		06/01/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077	•	
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F 676	Continued From pa	age 5	F 67	76		
	treatment and serv or her ability to carr	sident is given the appropriate ices to maintain or improve his ry out the activities of daily se specified in paragraph (b)				
	,	ovide care and services in aragraph (a) for the following				
	§483.24(b)(1) Hygi grooming, and oral	ene -bathing, dressing, care,				
	§483.24(b)(2) Mobineluding walking,	ility-transfer and ambulation,				
	§483.24(b)(3) Elim	ination-toileting,				
	§483.24(b)(4) Dinir snacks,	ng-eating, including meals and				
	(i) Speech, (ii) Language, (iii) Other functiona This REQUIREMEI by:	munication, including I communication systems. NT is not met as evidenced				
	review, the facility fand personal hygie	tion, interview and document failed to provide routine baths ne for one of one residents or activities of daily living		F (F676) PLAN OF CORRECTION Woodlyn Heights Senior Living de violated any federal or state regula Accordingly, this plan of correction not constitute an admission or agr	ations. n does	
	Findings include:			by the provider to the accuracy of facts alleged or conclusions set fo	the rth in	
		Minimum Data Set (MDS), cated R267 was cognitively		the statement of deficiencies. The corrections is prepared and/or exe	•	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	l \ '	(X3) DATE SURVEY COMPLETED	
		245320	B. WING _			C 01/2023	
NAME OF F	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
				2060 UPPER 55TH STREET EAST			
WOODLY	N HEIGHTS HEALTH	ICARE CENTER		INVER GROVE HEIGHTS, MN 550	77		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 676	Continued From pa	age 6	F 67	6			
	transfers, bed mob	extensive assistance with ility, locomotion on and off the toilet use and limited rsonal hygiene.		solely because it is required by provisions of federal and state Completion dates are provided procedural processing purpost correlation with the most rece	e law. d for ses and		
	several medical dia	agnosis list indicated R267 had agnoses including severe ease and acquired absence of nee.		completed or accomplished contaction and do not correspond chronologically to the date the maintains it is in compliance v	facility		
	interventions to ass bathing and indicat staff member for di assistance with toil	dated 5/8/23, lacked any sist R267 with showering or ed R267 needed assist of one ressing/undressing and eting and occasional		1. In continuing compliance w F (676), Activities of Daily Livi (ADLs)/Mntn Abilities. Woodly	requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (676), Activities of Daily Living (ADLs)/Mntn Abilities. Woodlyn Heights		
	incontinence episodes. R267's Tasks in the electronic medical record (EMR) indicated R267 received one bath, on 5/15/23, since admission on 5/8/23. During an interview and observation on 5/30/23 at 7:35 a.m., R267 stated she had one bed bath			Senior Living corrected the de- updating R267 care plan to in- bathing and personal hygiene and interventions on 06/29/23 care plans were reviewed on 0 DON to ensure bathing and per hygiene assistance and interventions.	clude assistance . All resident 07/6/23 by ersonal		
	"they just kind of slath". R267 was was pajama shirt and ligation appeared dishevel back.	nitted to the facility and stated, kip over me when it's time for a earing a grey, button-down ght pink shorts. R267's hair ed and matted down in the		2. To correct the deficiency and the problem does not recur, a staff were educated on 07/6/2 their next scheduled shift on a routine bathing and personal bathing askedules were added	Il nursing 3 or prior to completing hygiene by DON. All		
	R267 was wearing	on 5/30/23 at 11:09 a.m., the same grey, button-down ght pink shorts as that		Task in POC to ensure timely and proper documentation by 07/06/2023.	completion		
	9:18 a.m., R267 wa button-down pajam	and interview on 5/31/23 at as wearing the same grey, ha shirt and light pink shorts as ed nobody had helped her with		3. The DON and/or designee and POC documentation for complete bathing and personal hygiene 3x/week for 4 weeks, then 2x/	letion of cares		

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING		` '	SURVEY PLETED
		245320	B. WING			06/0) 01/2023
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E	BE	(X5) COMPLETION DATE
F 676	stated, "I couldn't exthey did not bring modern they did not bring modern and 2:03 p.m., R267 was crying, stating she has since Friday and stimulation washcloths or tower tower and stimulation as a.m., R267 was button-down pajaments."	ne that morning and further ven wash my face because he washcloths or towels". It dobservation on 5/31/23 at as out in the facility hallway, had been in the same clothes all had not received any ls to wash up with. It and interview on 6/1/23 at as wearing the same grey, a shirt from 5/30/23.	F 6	weeks, and then randomly continued compliance. 4. As part of Woodlyn Height Living ongoing commitment assurance, the DON and/or report identified concerns the community's QA Process.	hts Senic t to qualit r designe	or ty ee will	
	nursing assistant (Nardex to know who NA-B further stated the nurse's station and day was Sunday eventhat the NAs documented that the NAs documented the	on 5/31/23 at 9:42 a.m., NA)-B stated the NAs use the at cares to provide a resident. there was a bath schedule at and confirmed R267's bath enings. NA-B also confirmed nented when a bath was given EMR. NA-B stated R267 does t could be particular on the					
	registered nurse (Rethat baths or showed they were schedule occasionally will get	on 6/1/23 at 8:08 a.m., N)-A stated it was expected ers were completed the day d. RN- A stated she t notified if a bath or shower is as to ask if they were					
	director of nursing (on 6/1/23 at 9:33 a.m., the (DON) stated the expectation d baths to be completed the duled.					
	A policy on ADLs w	as requested but not received.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	`	3) DATE SURVEY COMPLETED
		245320	B. WING		C 06/01/2023
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	D 4TC
	S483.25(b) Skin Int §483.25(b)(1) Press Based on the compresident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with professional standar pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with professional standar promote healing, promote healing of pressure review the facility from the proper in healing of pressure resident (R2) review findings include: R2's quarterly Minit 3/3/23, indicated R2 quarterly M2 qu	egrity sure ulcers. brehensive assessment of a must ensure that- es care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and bressure ulcers receives and services, consistent candards of practice, to revent infection and prevent	F 686	F (F686) PLAN OF CORRECTION Woodlyn Heights Senior Living denies violated any federal or state regulation Accordingly, this plan of correction do not constitute an admission or agreem by the provider to the accuracy of the facts alleged or conclusions set forth i the statement of deficiencies. The pla corrections is prepared and/or execute solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond	ns. es nent n n of ed
	between a bed and hydraulic power). T had a stage IV, fac	a chair using electrical or he MDS further indicated R2 lity acquired pressure injury on en wound on the tailbone with		chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1 ` ′	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			C 0 1/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	Continued From proceed full thickness tissue tendon, or muscle R2's Medical Diagration of diagnosis of multiple disabling disease R2's Physician or an active order for meals only, other on her side to relie R2's care plan, dalimited physical mup in her wheelch transferred to be R2's entire electrol lacked documentation active order for meals only, other wheelch are specifically and the side of the R2's entire electrol lacked documentation active order for meals. During continuous 8:13 a.m. to 1:00 in her wheelchair R2 to bed or repositioning observation.	page 9 July le loss with exposed bone, e). Ignosis list indicated R2 had a ple sclerosis (a potentially of the brain and spinal cord). Iders, dated 3/19/19, indicated r R2 to be up in her wheelchair nerwise to be in bed, positioned ef pressure from her tailbone. Inted 12/23/22, indicated R2 had obility with an intervention to be air for meals only and 130 minutes after each meal. Indic medical record (EMR) ation or evidence of R2 refusing and, or laying down in bed Sobservation on 5/31/23 from p.m., R2 was out of bed, sitting without staff offering to transfer	F 6		ce with es to cer. Woodlyn ected the 2 and found o negative 01/23. R2 care e turning and s by DON on ints' skin and viewed by DON each resident ons in place for pressure siting schedules in POC to tion and/or /23. y and to ensure r, all nursing /06/23 or prior ft on pressure s including per resident care		
	During observation was in her wheeld with breakfast and During observation was brought back	n on 5/31/23 at 8:47 a.m., R2 hair in the dining room, done		turning and repositioning of 5 residents 3x/week for 8 weeks, and to ensure continued complete DON and/or designee will a for appropriate intervention prevention and healing of prince of 3 residents per weeks, 2 residents per wee	on random shifts 4 weeks, then then randomly liance. The audit care plans as for pressure week for 4 ek for 8 weeks,		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONSTRUCTION DING	l \ /	E SURVEY IPLETED
		245320	B. WING		06	C / 01/2023
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u>	01/2023
WOODLY	YN HEIGHTS HEALTH	ICARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 550)77	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE
F 686	Continued From pa	ige 10	F 6	686		
	facility staff entered intravenous medical transfer R2 into bed her wheelchair.	on 5/31/23 at 9:11 a.m., R2's room to set up her ations but did not offer to d or help her shift positions in on 5/31/23 at 9:53 a.m., R2		compliance.		
		tting in her wheelchair.				
		on 5/31/23 at 10:40 a.m., R2 tting in her wheelchair.				
	was in her room, sit	on 5/31/23 at 11:42 a.m., R2 tting in her wheelchair. A NA) entered to take R2 out to chair.				
		on 5/31/23 at 12:53 p.m., R2 inch, sitting in her wheelchair om.				
	1:00 p.m., R2 was lift. R2 stated her ta the longer she sat u it hurt. R2 further st	and interview on 5/31/23 at laid down in bed via a Hoyer ailbone area was sore and that up in her wheelchair, the more lated facility staff did not offer ed between breakfast and				
	stated R2 needed a activities of daily live nursing assistants of breakfast and lay holder lunch. NA-C stated R2 down between keep layer and layer lay	on 6/1/23 at 7:16 a.m., NA-C assistance from staff with all ing (ADLs). NA-C stated the get R2 up in her chair before er back down in bed after facility staff do not offer to lay breakfast and lunch and R2 se cares from facility staff.				
	During an interview	on 6/1/23 at 7:23 a.m.,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245320	B. WING _			C 01/2023	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 686	familiar with R2's casheet which RN-B conformation on how further reviewed R2 record (MAR) which her wheelchair for record (MAR) which her wheelchair for mean on her sacrum. OT importance of this known appropriate for her support she needs. During an interviewed director of nursing or refuses cares or to confirmed there we address R2's potentiand that the EMR larefusals. The DON comprehensive assembled would not agree to facility acquired prepressure injuries for stated they do not have a policy on pressure we have a policy on pressure and the pressure we have a policy on pressure we have a policy on pressure and the pressure we have a policy on pressure and the pressure we have a policy on pressure and the pressure we have a policy on pressure and the pressu	N)-B stated she was not ares. RN-B checked R2's care confirmed lacked any often to reposition R2. RN-B 2's medication administration in indicated R2 was to be up in meals only. on 5/31/23 at 1:53 p.m., bist (OT)-A stated R2 does der to only be in her ls due to the pressure injury-A further stated the pecause R2's wheelchair is not as it does not give her the con 6/1/23 at 7:48 a.m., the (DON) stated that R2 often be repositioned. The DON re no interventions in place to tall refusals for repositioning acked documentation of further stated the EMR lacked dessments of what R2 would or to promote healing of her essure injury or to prevent new rm developing. The DON have a proactive plan to sure injuries stating, "I don't		6			
F 688 SS=D	not received. Increase/Prevent D CFR(s): 483.25(c)(ecrease in ROM/Mobility 1)-(3)	F 68	8		7/6/23	
	§483.25(c) Mobility	•					

1 ` ′		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			C 01/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077	1 00/0	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETION DATE
F 688	resident who enter range of motion do range of motion un condition demonst of motion is unavous §483.25(c)(2) A remotion receives apservices to increase prevent further deceives appropriate assistance to main the maximum practicution in mobility. Based on observative with a facility from their upper extremely motion to one of orange of motion with their upper extremely motion to one of orange of motion with their upper extremely findings include: R2's quarterly Min 3/3/23, indicated Findings include: R2's quarterly Min 3/3/23, indicated Findings include: R2's quarterly Min 3/3/23, indicated Findings include: R2's quarterly Min 3/3/24, indicated Findings include: R2's quarterly Min 3/3/25, indicated Findings include: R2's quarterly Min 3/3/26, indicated Findings include:	facility must ensure that a rest the facility without limited pees not experience reduction in pless the resident's clinical crates that a reduction in range pidable; and sident with limited range of appropriate treatment and se range of motion and/or to crease in range of motion. sident with limited mobility are services, equipment, and artain or improve mobility with exticable independence unless a try is demonstrably unavoidable. ENT is not met as evidenced ation, interview and document failed to provide range of the resident (R2) reviewed for the had limited range of motion	F 6	F (F688) PLAN OF CORRECTION Woodlyn Heights Senior Living den violated any federal or state regular Accordingly, this plan of correction not constitute an admission or agre by the provider to the accuracy of t facts alleged or conclusions set for the statement of deficiencies. The corrections is prepared and/or execution services of the provisions of federal and state law. Completion dates are provided for procedural processing purposes ar correlation with the most recently completed or accomplished correct action and do not correspond chronologically to the date the facili maintains it is in compliance with the requirements of participation, or the	tions. does ement he th in plan of cuted ity he ity	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` ′		· /	TE SURVEY MPLETED	
	245320	B. WING		06	C / 01/2023
PROVIDER OR SUPPLIER	CARE CENTER		2060 UPPER 55TH STREET EAST	<u>.</u>	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
R2's care plan, date a nursing rehabilitate of motion to her bill daily with the follows. 1. Fingers into a fist 2. Thumb touch to e 3. fingers spread and 4. wrist up and down 5. Palm up, then pass 6. Palm up, then pass 6. Palm up-touch so 7. Elbow close to be abdomen 8. Right arm, with the light 9. Left arm, thumb shoulder height. R2's nursing assists medical record (EM range of motion (R0 upper extremities of instructions: 1. Fings Thumb touch to each apart then together up, then palm down shoulder, then strail body, rotate hand of arm, with thumb up Left arm, thumb up shoulder height. R2 indicated the facility program six (6) times of the program six (6) times the program of the prog	f the brain and spinal cord). ed 12/23/23, indicated R2 had tion program for passive range ateral upper extremities once ing instructions: then out each fingertip part then together result down rotation shoulder, then straighten elbow ody, rotate hand out and to numb up, extends arm to face up, assist to extend arm up to eant (NA) tasks in the electronic (R) indicated R2 had a passive OM) program to her bilateral nace daily with the following pers into a fist, then out 2. In the chart of the content of the co		1. In continuing compliance win F(688), Increase /Prevent Deck ROM/Mobility. Woodlyn Height Living corrected the deficiency reviewing R2 and all like reside plans to ensure nursing rehability was appropriate and tasked in correctly to ensure timely completed documentation on 07/06/23 by 2. To correct the deficiency and the problem does not recur, all staff were educated on 07/06/2 to their next scheduled shift on timely completion of all nursing programs. 3. The DON and/or designee we POC documentation of all resignary rehability program for time completion 3x/week for 4 week 2x/week for 8 weeks, and then to ensure continued compliance. 4. As part of Woodlyn Heights Living ongoing commitment to assurance, the DON and/or designeed to the problem of the problem	th rease in s Senior by ent care program POC oletion and DON. It to ensure nursing a or prior ensuring rehab vill audit dents on ely s, then randomly e. Senior quality signee will	
occupational therap	oist (OT)-A stated R2 was on				
	PROVIDER OR SUPPLIER (N HEIGHTS HEALTH SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa disabling disease of motion to her bilated of her	PROVIDER OR SUPPLIER TO HEIGHTS HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 disabling disease of the brain and spinal cord). R2's care plan, dated 12/23/23, indicated R2 had a nursing rehabilitation program for passive range of motion to her bilateral upper extremities once daily with the following instructions: 1. Fingers into a fist, then out 2. Thumb touch to each fingertip 3. fingers spread apart then together 4. wrist up and down 5. Palm up, then palm down rotation 6. Palm up- touch shoulder, then straighten elbow 7. Elbow close to body, rotate hand out and to abdomen 8. Right arm, with thumb up, extends arm to face height 9. Left arm, thumb up, assist to extend arm up to shoulder height. R2's nursing assistant (NA) tasks in the electronic medical record (EMR) indicated R2 had a passive range of motion (ROM) program to her bilateral upper extremities once daily with the following instructions: 1. Fingers into a fist, then out 2. Thumb touch to each fingertip 3. fingers spread apart then together 4. wrist up and down 5. Palm up, then palm down rotation 6. Palm up- touch shoulder, then straighten elbow 7. Elbow close to body, rotate hand out and to abdomen 8. Right arm, with thumb up, extends arm to face height 9. Left arm, thumb up, assist to extend arm up to shoulder height. R2's task documentation	PROVIDER OR SUPPLIER (N HEIGHTS HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 disabling disease of the brain and spinal cord). R2's care plan, dated 12/23/23, indicated R2 had a nursing rehabilitation program for passive range of motion to her bilateral upper extremities once daily with the following instructions: 1. Fingers into a fist, then out 2. Thumb touch to each fingertip 3. fingers spread apart then together 4. wrist up and down 5. Palm up, then palm down rotation 6. Palm up- touch shoulder, then straighten elbow 7. Elbow close to body, rotate hand out and to abdomen 8. Right arm, with thumb up, extends arm to face height 9. Left arm, thumb up, assist to extend arm up to shoulder height. R2's nursing assistant (NA) tasks in the electronic medical record (EMR) indicated R2 had a passive range of motion (ROM) program to her bilateral upper extremities once daily with the following instructions: 1. Fingers into a fist, then out 2. Thumb touch to each fingertip 3. fingers spread apart then together 4. wrist up and down 5. Palm up, then palm down rotation 6. Palm up- touch shoulder, then straighten elbow 7. Elbow close to body, rotate hand out and to abdomen 8. Right arm, with thumb up, extends arm to face height 9. Left arm, thumb up, assist to extend arm up to shoulder height. R2's task documentation indicated the facility NAs had completed the ROM program six (6) times in the past 30 days. During an interview on 5/31/23 at 1:53 p.m., occupational therapist (OT)-A stated R2 was on	PROVIDER OR SUPPLIER (N HEIGHTS HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13	ROVIDER OR SUPPLIER 245320 245320 245320 245320 245320 25TREET ADDRESS, CITY, STATE, ZIP CODE 2000 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) R2's care plan, dated 12/23/23, indicated R2 had a nursing rehabilitation program for passive range of motion to her bilateral upper extremities once daily with the following instructions: 1. Fingers into a fist, then out 2. Thumb touch to each fingertip 3. fingers spread apart then together 4. wrist up and down 5. Palm up, then palm down rotation 6. Palm up, then palm down rotation 6. Palm up, then balm down that the model are cord (EMR) indicated R2 had a passive range of motion (ROM) program to her bilateral upper extremities once daily with the following instructions: 1. Fingers into a fist, then out 2. Thumb touch to each fingertip 3. Left arm, thumb up, assist to extend arm up to shoulder height. 2. To correct the deficiency by reviewing R2 and all like resident care plans to ensure nursing rehab program was appropriate and tasked in POC correctly to ensure timely completion and documentation on 07/06/23 by DON. 2. To correct the deficiency and to ensure the problem does not recur, all nursing staff were educated on 07/06/23 or prior to their next scheduled shift on ensuring timely completion of all nursing rehab programs. 3. The DON and/or designee will audit POC documentation of all residents on nursing rehab program for timely completion 3x/week for 4 weeks, and then randomly to ensure continued compliance. 4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	` '	E SURVEY IPLETED	
		245320	B. WING		06/	C '01/2023
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 732	ROM with R2. During an interview nursing assistant (Nof a ROM program it herself." NA-C furrefuse cares. During an interview director of nursing (aware of a ROM program it. The DOI care plan, the expectompleted. A policy on ROM program it. The DOI care plan, the expectompleted. A policy on ROM program it. The DOI care plan, the expectompleted. A policy on ROM program it. The DOI care plan, the expectompleted. A policy on ROM program it. The DOI care plan, the expectompleted. A policy on ROM program it. The DOI care plan, the expectompleted. S483.35(g) Nurse S483.35(g)(1) Data must post the follow basis: (i) Facility name. (ii) The current data (iii) The total number by the following cate unlicensed nursing resident care per shad) Registered nursing resident care per shad. (B) Licensed practices	on 6/1/23 at 7:16 a.m., NA)-C stated he was unaware for R2 and stated, "she can do ther stated R2 does not often on 6/1/23 at 9:33 a.m., the DON) stated she was not ogram for R2 and if she was N further stated if it was on the ctation was for it to be ograms was requested but not ng Information 1)-(4) staffing Information. requirements. The facility ving information on a daily e. er and the actual hours worked egories of licensed and staff directly responsible for nift:		732		7/6/23
	(C) Certified nurse (iv) Resident census (iv) Resident census §483.35(g)(2) Posti	S.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	` '	E SURVEY IPLETED
		245320	B. WING		06/	C 01/2023
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	01/2020
WOODL	YN HEIGHTS HEALTH	CARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
F 732	Continued From pa	ge 15 post the nurse staffing data	F 7	732		
	specified in paragradaily basis at the be (ii) Data must be po (A) Clear and reada	aph (g)(1) of this section on a eginning of each shift. sted as follows: able format. clace readily accessible to				
	staffing data. The f written request, ma	c access to posted nurse facility must, upon oral or ke nurse staffing data lic for review at a cost not to nity standard.				
	posted daily nurse s 18 months, or as re is greater.	ity data retention facility must maintain the staffing data for a minimum of equired by State law, whichever				
	failed to ensure dai was posted in a time shift and in a place visitors. This had the	tion and interview the facility ly nurse staffing information ely manner at the start of the visible to residents and le potential to affect all 63 d visitors who wanted to review		F 732 PLAN OF CORRECTION Woodlyn Heights Senior Living of violated any federal or state regulated any federal or state regulated any federal or state regulated and the correction of constitute an admission or as by the provider to the accuracy of facts alleged or conclusions set	ulations. on does greement of the	
	Findings include: During entrance to	the nursing home on Monday,		the statement of deficiencies. The corrections is prepared and/or exposely because it is required by the statement of deficiencies.	ne plan of xecuted	
	5/30/23 at 11:00 a.r	n., the administrator in training e the daily nurse staffing		provisions of federal and state la Completion dates are provided f procedural processing purposes correlation with the most recently	or and	
	daily nurse staffing	on 5/31/23 at 8:19 a.m., the information was located on he first-floor nurse's station.		completed or accomplished corraction and do not correspond chronologically to the date the fa		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	COM	X3) DATE SURVEY COMPLETED	
		245320	B. WING _			C 01/2023	
	ROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 732	visible to residents staffing information. During an observate daily nurse staffing 5/30/23 and not visible to responsible to responsible for hand information at the staffing coordinator nurse staffing information at the data of:30 a.m. or 7:00 at the weekends. The	nurse's station and was not or visitors. The daily nurse was dated 5/30/23. ion 5/31/23 at 10:14 a.m., the information was still dated ible to residents or visitors. on 6/1/23 at 9:22 a.m., the information was dated 5/31/23	F 7		mation. rected holder to the on more ere f e the for 4 ire nior lity and/or erns		
F 757 SS=D	received. Drug Regimen is F CFR(s): 483.45(d)(§483.45(d) Unnece Each resident's dru unnecessary drugs drug when used-	essary Drugs-General. Ig regimen must be free from . An unnecessary drug is any	F 7	57		7/6/23	
	§483.45(d)(1) In exduplicate drug there	cessive dose (including apy); or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		
245320	B. WING _			3
ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPL	ETION
ige 17	F 7	57		
excessive duration; or				
out adequate monitoring; or				
out adequate indications for its				
ch indicate the dose should be				
NT is not met as evidenced tion, interview, and document ailed to ensure al interventions were orded prior to the seneeded (PRN) narcotic facilitate person-centered care the risk of complication (i.e., ion) for 2 of 5 residents (R46, unnecessary medication use.		violated any federal or state regular Accordingly, this plan of correction not constitute an admission or agree by the provider to the accuracy of the facts alleged or conclusions set for the statement of deficiencies. The corrections is prepared and/or executed by the provisions of federal and state law. Completion dates are provided for procedural processing purposes are correlation with the most recently completed or accomplished correct action and do not correspond chronologically to the date the facil maintains it is in compliance with the requirements of participation, or the	tions. does ement he th in plan of cuted tive ity ne	
	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 17 excessive duration; or out adequate monitoring; or out adequate indications for its e presence of adverse ch indicate the dose should be inued; or combinations of the reasons as (d)(1) through (5) of this NT is not met as evidenced tion, interview, and document failed to ensure cal interventions were created (PRN) narcotic facilitate person-centered care the risk of complication (i.e., ion) for 2 of 5 residents (R46, inunecessary medication use. Alimum Data Set (MDS), dated R46 had intact cognition, elusional thinking or beliefs, sive assistance with several ring (ADLs). In addition, the received both scheduled and ons during the review; receive any non-medication in. Further, R46 indicated they	A. BUILDIE 245320 B. WING_ A. BUILDIE 245320 B. WING_ A. BUILDIE B. WING_ B. WING_ B. WING_ PREFIX TAG TAG TAG TAG TAG TAG TO SECONDAL SEPRECEDED BY FULL SCIDENTIFYING INFORMATION) F. 75 B. EXCRESSIVE duration; or out adequate monitoring; or out adequate indications for its B. EXCRESSIVE durations for its B. WING_ PREFIX TAG TAG TAG TO SECONDAL SEPRECEDED BY FULL SCIDENTIFYING INFORMATION) F. 75 B. WING_ PREFIX TAG TO SECONDAL SEPRECEDED BY FULL SCIDENTIFYING INFORMATION) F. 75 B. WING_ PREFIX TAG TO SECONDAL SEPRECEDED BY FULL SCIDENTIFYING INFORMATION) F. 75 B. WING_ PREFIX TAG TO SECONDAL SEPRECEDED BY FULL SCIDENTIFYING INFORMATION) F. 75 B. WING_ PREFIX TAG TO SECONDAL SEPRECEDED BY FULL SCIDENTIFYING INFORMATION) F. 75 B. WING_ PREFIX TAG F. 75 B. WING_ B. WING	A BUILDING 245320 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2660 UPPER S5TH STREET EAST INVER GROVE HEIGHTS, MN 55077 INVER GROVE HEIGHTS, MN 5507 INVER GROVE HEIGHTS, MN 55077 INVER GROVE HEIGHTS, MN 55077 INVER GROVE HEIGHTS, MN 55077 INVER GROVE HEIGHTS, MN 5507 INTER STATET LAST INVER GROVE HEIGHTS, MN 5507 INVER GROVE HEIGHTS, MN 50	IDENTIFICATION NUMBER: 245320 B. WING

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		PLETED
		245320	B. WING _			C 01/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 757	had actual pain with management and linterruption in norm. The care plan lister meet this goal which non-pharmacologic such as music, report R46's Order Summidentified R46's current medications and trorders for acetamin 1000 milligrams (min addition, twice a (a narcotic pain metimes a day PRN for corresponding Med (MAR), dated 4/20 ordered medication demonstrate administered over including the follow. On 4/2/23 at 10:22 pain at 7/10, and the "Effective." A corresponding the follow. On 4/2/23, identified the including the follow. On 4/3/23 at 12:44 pain at 6/10, and the offered or attempted of the follow.	ated 3/11/23, identified R46 h needing medication isted a goal, "Will not have an hal activities due to pain" d interventions to help R46 ch included, "Offer cal interventions for pain relief cositioning, massage[,] etc." hary Report, dated 5/1/23, rrent physician-ordered eatments. This included active hophen (a mild pain reliever) hg) twice a day scheduled and, day PRN for pain; and Norco edication) 5-325 mg up to three or "severe pain." R46's dication Administration Records 23 and 5/2023, identified R46's hs with corresponding initials to histration. This identified R46 bees of the PRN Norco the previous two month period	F 75	1. In continuing compliance with F(757), Drug Regimen is Free fror Unnecessary Drugs. Woodlyn Heig Senior Living corrected the deficient reviewing R46, R267, and all like residents with orders for PRN narounder medications to ensure non-pharmacological interventions place on 07/06/23. 2. To correct the deficiency and to the problem does not recur, all nurstaff were educated on 07/06/23 or to their next scheduled shift on attended and documenting all non-pharmacointerventions prior to the administrative pRN narcotics. 3. The DON and/or designee will a MARs/TARs for attempt of non-pharmacological interventions residents receiving PRN narcotics 3x/week for 4 weeks, then 2x/week weeks, and then randomly to ensure continued compliance. 4. As part of Woodlyn Heights Sent Living ongoing commitment to qualessurance, the DON and/or design report identified concerns through community's QA Process.	ghts ncy by cotic are in ensure sing r prior empting ological ation of udit of all k for 8 re ior lity nee will	
		ne medication was given with				

, , , , , , , , , , , , , , , , , , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED			
		245320	B. WING			01/2023		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 757	no indication or sy any, non-pharmaco offered or attempt On 4/4/23 at 5:30 at 5/10, and the results being listed again, neither of the non-pharmacologion attempted prior On 4/6/23 at 5:32 at 4/10, and the results being listed again, neither of the non-pharmacologion attempted prior On 4/6/23 at 5:32 at 4/10, and the results being listed again, neither of the non-pharmacologion attempted prior On 4/6/23 at 5:32 at 4/10, and the results being listed again, neither of the non-pharmacologion attempted prior On 4/6/23 at 5:32 at 4/10, and the results being listed again, neither of the non-pharmacologion attempted prior On 4/6/23 at 5:32 at 4/10, and the results being listed again, neither of the non-pharmacological at 6/10, and the results being listed again, non-pharmacological at 6/10, and the results being listed at 100 at 10	mptoms recorded; nor what, if cological interventions were ed prior to administration. a.m., with R46 rating their pain esults being listed as, esponding progress note, dated he medication was given with emptoms recorded; nor what, if cological interventions were ed prior to administration. B a.m., with R46 rating their he results being listed as, esponding progress note, dated he medication was given with emptoms recorded. In addition, provided on 4/5/23 at 7:59 ng their pain at 7/10, and the das, "Effective." However, he notes identified what, if any, cal interventions were offered	F 75					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245320	B. WING	;	06/	C 01/2023
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077	1 00/	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		LD BE	(X5) COMPLETION DATE
F 757	Continued From pa	ge 20	F	757		
	pain at 5/10, and the "Effective." A correst 4/25/23, identified to no indication or synany, non-pharmaco offered or attempte. On 5/4/23 at 3:18 pat 6/10, and the rest "Effective." A correst 5/4/23, identified the no indication or synany, non-pharmaco offered or attempte. R46's medical reconcevidence of what, if interventions were extended to administration of the administration of the administration of the synany and the administration of the administration of the administration of the synany and the administration of t	A p.m., with R46 rating their e results being listed as, sponding progress note, dated he medication was given with aptoms recorded; nor what, if logical interventions were d prior to administration. .m., with R46 rating their pain all the being listed as, sponding progress note, dated e medication was given with aptoms recorded; nor what, if logical interventions were d prior to administration. Indicate the prior to administration and lacked any, non-pharmacological offered or attempted prior to administered doses from administered doses from				
	laying in bed while is comfortable and with symptoms of pain (was interviewed and many medications as seemed to have an take. R46 stated the severe pain due to migraines; and expendent acetaminophe control it. R46 stated time" in recent monnon-pharmacological	a.m., R46 was observed in their room. R46 appeared thout obvious physical i.e., grimacing, yelling). R46 d explained they consumed as each physician visit other "add on" for them to ey do, at times, have mild to arthritis and a history of lained they consumed Norco en just wasn't enough to ed they could only recall "one this when staff had offered any al interventions to them prior wever, added they were				

 ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	, ,	DATE SURVEY COMPLETED
		245320	B. WING			C 06/01/2023
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 757	unsure what, if any interventions may have the work of nursing assistant (Nan "extensive amount and, at times, would knees from arthritis it," and explained the complain about heat stated if R46 completed would be to notify the address it adding the had never been dire or heat packs or other interventions with Resistered nurse (Resistered nurse (Resist	non-pharmacological algorithms and selp the pain. on 5/31/23 at 8:20 a.m., NA)-A explained R46 needed ant of help" with most cares of complain of pain in their and t		57		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILE	LTIPLE CONSTRUCTION DING	` '	TE SURVEY MPLETED	
		245320	B. WING	;	06	/ 01/2023
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 757	explained R46's canon-pharmacologic staff should be atterable all PRN narcotic adwas no evidence thattempted or offere each administration any." RN-B verified attempt and docum approaches prior to adding, "They're sure RN-B stated it was non-pharmacologic the administration of narcotics could cause R267's admission of dated 5/14/23, indicintact and needed exeveral ADLs.	R46's medical record. RN-B re plan had al interventions listed which mpting and documenting with ministrations, however, there e interventions were d in the medical record with adding, "I am not seeing staff were supposed to ent their non-pharmacological giving PRN medication pposed to do their notes." important to offer and attempt al approaches to help "reduce of medication," and they added see potential addiction. Minimum Data Set (MDS), cated R267 was cognitively extensive assistance with		757		
	R267 had an order pain medication) five four (4) hours PRN R267's care plan, de had "actual/potential medication manage "offer non-pharmac relief such as musical R267's treatment relief.	for Oxycodone (a narcotic re (5) milligrams (mg) every (as needed) for severe pain. lated 5/8/23, indicated R267 al" for pain with need for ement, with an intervention to cological interventions for pain c, repositioning, massage etc". ecord, dated 5/8/23, indicated pserve pain every shift and				
	document any verb of pain and interver	al and/or non-verbal indicators				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		` '	TE SURVEY MPLETED
	245320	B. WING	;	06	C /01/2023
PROVIDER OR SUPPLIER	CARE CENTER		2060 UPPER 55TH STREET EAST	<u>'</u>	
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE
progress note. R267's medication indicated R267 receleven (11) occasion facility on 5/8/23 incomplete of the progress of the series of the se	administration record eived PRN Oxycodone on one since admission to the cluding the following: a.m., with a documented pain ale of one (1)-10. p.m., with a documented pain le of one (1)-10 and on 11:41 ented pain rating of 7 on a p.m., with a documented pain le of one (1)-10 and 11:58 ented pain rating of 3 on a a.m., with a documented pain le of one (1)-10 and 6:13 p.m., pain rating of 7 on a scale of 7 p.m., with a documented a scale of one (1)-10. 5 a.m., with a documented a scale of one (1)-10. 9 p.m., with a documented pain le of one (1)-10.		757		
	PROVIDER OR SUPPLIER (N HEIGHTS HEALTH SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa progress note. R267's medication indicated R267 rece eleven (11) occasion facility on 5/8/23 inco On 5/9/23 at 9:37 prating of 10 on a sca On 5/10/23 at 4:47 rating of 8 on a sca On 5/11/23 at 8:02 rating of 7 on a sca p.m., with a docume scale of one (1)-10 On 5/17/12 at 8:27 rating of 7 on a sca p.m., with a docume scale of one (1)-10 On 5/18/23 at 5:29 rating of 5 on a sca with a documented one (1)-10. On 5/19/23 at 11:27 pain rating of 6 on a On 5/24/23 at 12:58 pain rating of 6 on a R267's entire electron R267's entire electron R267's entire electron	PROVIDER OR SUPPLIER // HEIGHTS HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 progress note. R267's medication administration record indicated R267 received PRN Oxycodone on eleven (11) occasions since admission to the facility on 5/8/23 including the following: On 5/9/23 at 9:37 p.m., with a documented pain rating of 10 on a scale of one (1)-10. On 5/10/23 at 4:47 p.m., with a documented pain rating of 8 on a scale of one (1)-10. On 5/11/23 at 8:02 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and on 11:41 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 11:58 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 11:58 p.m., with a documented pain rating of 5 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 5 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 5 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 5 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m.	PROVIDER OR SUPPLIER (N HEIGHTS HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 progress note. 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R267's entire electronic medical record (EMR),	PROVIDER OR SUPPLIER (N HEIGHTS HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 progress note.	PROVIDER OR SUPPLIER 245320 245320 245320 245320 245320 245320 245320 245320 25 STREET ADDRESS, CITY, STATE, ZIP CODE 2000 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 progress note. R267's medication administration record indicated R267 received PRN Oxycodone on eleven (11) occasions since admission to the facility on 5/8/23 including the following: On 5/9/23 at 9:37 p.m., with a documented pain rating of 10 on a scale of one (1)-10. On 5/10/23 at 8:02 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 11:58 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 5 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 6 on a scale of one (1)-10. On 5/19/23 at 11:27 p.m., with a documented pain rating of 6 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 6 on a scale of one (1)-10. On 5/19/23 at 11:27 p.m., with a documented pain rating of 6 on a scale of one (1)-10. On 5/19/23 at 7:14 p.m., with a documented pain rating of 7 on a scale of one (1)-10 and 6:13 p.m., with a documented pain rating of 6 on a scale of one (1)-10. On 5/19/23 at 7:14 p.m., with a documented pain rating of 7 on a scale of one (1)-10. On 5/31/23 at 7:14 p.m., with a documented pain rating of 7 on a scale of one (1)-10. On 5/31/23 at 7:14 p.m., with a documented pain rating of 7 on a scale of one (1)-10.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245320	B. WING			C 01/2023	
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPROPRIES OF CROSS-REFERENCE)	JLD BE	(X5) COMPLETION DATE	
F 757	Continued From pa	age 24	F 7	57			
	were offered or attended administration. The assessments of R2 or location of pain. During an interview registered nurse (R for a PRN pain med expected to do a pawhat was going on resident's pain level progress note. RN-offering non-pharm pain and document progress note so stor does not work for reviewed R267's pathere were no document of the reviewed R267's path	empted prior to Oxycodone EMR further lacked 267's pain to include symptoms on 6/1/23 at 8:08 a.m., RN)-A stated if a resident asked dication the nurses were ain assessment of what hurts, to cause the pain and the el and document it in a A stated the nurses should be accological interventions for ting the interventions in a taff were aware of what works or each resident. RN-A rogress notes and confirmed amented pain assessments or armacological pain					
	director of nursing was for nurses to of interventions for particular non-pharmacologic planned but nurses non-pharmacologic being offered or trief. When interviewed consulting pharmace expectation was for the second consulting pharmace.	on 5/31/23 at 1:04 p.m., the cist (CP) stated the r staff to attempt and					
	•	pharmacological interventions administration. CP added, "It's sue."					
F 804 SS=E		ear, Palatable/Prefer Temp	F 8	04		7/7/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			C 01/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE APDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 804	§483.60(d)(1) Food conserve nutritive views at temperature. This REQUIREME by: Based on observative at warm, paresidents (R19, R4 observed to be serinappropriate food. Findings include: R19 R19's quarterly Mir 3/13/23, indicated. During interview or stated she declined food is cold". During interview with 5/31/23 at 9:18 a.m. about cold food is cold is cold.	nd drink vives and the facility provides- d prepared by methods that value, flavor, and appearance; d and drink that is palatable, safe and appetizing NT is not met as evidenced vition, interview and document ailed to ensure food was alatable temperatures for 3 of 3 of 3 of 3 and R267) who were ved and/or complained about		F 804 PLAN OF CORRECTION Woodlyn Heights Senior Living violated any federal or state re Accordingly, this plan of corre not constitute an admission or by the provider to the accurac facts alleged or conclusions se the statement of deficiencies. corrections is prepared and/or solely because it is required be provisions of federal and state Completion dates are provided procedural processing purpos correlation with the most recel completed or accomplished or action and do not correspond chronologically to the date the maintains it is in compliance we requirements of participation, corrective action was necessar 1. In continuing compliance we F 804, Nutritive Value/Appear,	egulations. ction does ragreement y of the et forth in The plan of rexecuted y the e law. d for es and ntly orrective facility with the or that ary.		
	dining room the food would be hotter". DM-A stated "we don't always have enough staff" to			Palatable/Prefer Temp. Wood Senior Living corrected the de	lyn Heights		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	(X3) DATE SURVEY COMPLETED	
		245320	B. WING _		C 06/01/2023
	PROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE COMPLÉTIC
F 804	During interview on stated, "food sucks sure" most of the ti has refused "hot placed". R46 stated the concerns and not buring an observat 8:18 a.m., dietary a room with a breakfacereal, carton of mi pieces of toast and asked surveyor to the show how warm the they were cool to the trays should be ser assistants and dietashould be helping to buring interview with 5/31/23 at 8:20 a.m. aware of the same "a lot of the resident "plated downstairs here finally". NA-As aware and their residents to eat their rooms. NA-As aware for the passishort staffed".	S dated 5/11/23, indicted R46 1. 1. 5/30/23 at 7:29 a.m., R46 ", and warm food is "cold for me it is served. R46 stated she ate stuff" because it is "always he facility staff were aware of so solutions were offered. ion and interview on 5/30/23 at ide (DA)-B entered R46's east tray that included a bowl of lik, two sausage links, two one hard-boiled egg. R46 ouch the sausage links to ey were. DA-B acknowledged he touch. DA-B stated the food wed by both the nursing ary aides, however the "aides as but don't". Ith nursing assistant (NA)-A on h., NA-A stated she had was complaints of cold food from ats". NA-A stated the food is and is cold when arrives up stated facility management is eponse is to encourage all of the dining room instead of stated nursing assistants " are strays often as kitchen will say		acquiring two CAMBRO Meal Delix Carts on 06/06/2023. 2. To correct the deficiency and to the problem does not recur all staff educated on 07/07/2023 on proper of new CAMBRO meal delivery cathe Dietary Manager. The Dietary I and/or designee will audit room tratemperatures 3 times per week for weeks and weekly for 8 weeks and randomly to ensure continued compliance. 3. As part of Woodlyn Heights Sen Living ongoing commitment to quates assurance, the Dietary Manager and designee will report identified condithrough the community's QA Processing the process of the process	ensure f were usage ts by langer y food 4 I then ior lity nd/or erns
		MDS dated 5/14/23, indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245320	B. WING _		06	/01/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 804	a.m., R267 stated cold". During interview wi a.m., R267 stated, breakfast today be cold by the time it go. During interview wi a.m., DA-A stated food is cold. It is hapassing the trays. In the second state of the passing the trays. It is a second state of the passing the trays. It is passing trays. It is pass	gnition. th R267 on 5/30/23 at 7:47 'most of the time the food is th R267 on 5/31/23 at 9:24 "I just ate cold cereal for cause the hot food is always	F 80)4			
	(LPN)-A on 5/31/23 know the food is not they (residents) get trays when we are lights." During interview with a.m., DM-A stated meet the needs of residents do not watto eat meals in the to eat in the dining resident meal trays force them to come stated the responsi	th licensed practical nurse at 9:42 a.m., LPN-A stated, "I of as hot as it should be when it. Hard to make time to pass passing meds and answering the DM-A on 5/31/23 at 10:23 there were enough staff to the residents but that the ant to come out of their rooms dining room. This reluctance room is the reason why the are cold. "I know we can't e out" of their rooms. DM-A ibility to pass meal trays is the e nursing assistants and that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(3) DATE SURVEY COMPLETED C	
		245320	B. WING			01/2023	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 804	food complaints.	aware of the issue with cold	F 804	4			
F 921	at 6:18 a.m., the actemperature complete administrator is a plan to arrange far before meal service much success. The dietary aides and not responsible for passible for passible should. The administration are getting being passed out.	In the administrator on 6/1/23 Iministrator stated the food aints is an "on-going issue". It stated the facility implemented acility activities immediately but that has not met with administrator stated the ursing assistants are sing meal trays and the do not help as much as they distrator stated, "yes, the g cold food when the trays are initary/Comfortable Environ	F 92	1		7/6/23	
SS=D	The facility must present sanitary, and comformation residents, staff and This REQUIREMENTAL by: Based on observative review the facility facility facility facility facility facility facility.	nvironmental Conditions ovide a safe, functional, ortable environment for the public. NT is not met as evidenced tion, interview, and record ailed to ensure a safe, itary living environment for 3 of		F 921 PLAN OF CORRECTION Woodlyn Heights Senior Living deni	ies it		
	environmental cond Findings include: During observation 7:33 a.m., R46 had along the bottom of to the bed. The rad	and interview on 5/30/23 at a brown-colored radiator the wall on the right side next iator was pulled several inches and was loose. R46 stated the		violated any federal or state regulating Accordingly, this plan of correction of not constitute an admission or agreed by the provider to the accuracy of the facts alleged or conclusions set forth the statement of deficiencies. The processor of the corrections is prepared and/or exect solely because it is required by the provisions of federal and state law. Completion dates are provided for	does ement ne th in olan of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			C 01/2023	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP C	<u>-</u>	01/2020	
				2060 UPPER 55TH STREET EAST			
WOODLY	YN HEIGHTS HEALTH	ICARE CENTER		INVER GROVE HEIGHTS, MN 5	5077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 921	Continued From pa	age 29	F 9	21			
	radiator had been t was told "someday	hat way for about a month and " it would be fixed.		procedural processing purpocerrelation with the most red completed or accomplished	cently		
	During observation	on 5/30/23 at a.m., R52 was		action and do not correspon			
		ing nutrition through a feeding		chronologically to the date the			
		f the pole was visibly soiled		maintains it is in compliance			
	•	ount of light-brown splattering		requirements of participation	•		
	from the feeding ward touch .	hich was dry to appearance		corrective action was neces	sary.		
				1. In continuing compliance	with		
		and interview on 5/30/23 at		F 921,			
	10:47 a.m., R54 was sitting in a chair in her room			Safe/Functional/Sanitary/Co			
	receiving oxygen from a NewLife Elite AirSep concentrator. The filter on the backside of the			Environment. Woodlyn Heig	'		
				Living corrected the deficient R46 brown-colored radiator	, ,		
		overed with copious and was nearly occluded. R54		On 5/30/23, Maintenance st			
		w what they do" in regards to	complete a work order system for				
		staff change or clean the filter.		residents that discharge to eare fixed. On 06/01/2023, the	ensure rooms		
	During an obsevati	on and interview on 06/01/23		Nurse cleaned R52 and all I			
		stered nurse (RN)-C verified		tube feeding poles. On 06/0			
	,	ck of the oxygen concentrator		and nurse changed R54 and	•		
		s dirty and stated the night		resident filters for the oxyge			
	•	ible for changing the tubing er verified the bottom of the		concentrator.			
		in R52's room) had dried and		2. To correct the deficiency	and to ensure		
		ering all over it and the night		the problem does not recur			
	nurse was also res	ponsible for cleaning it. RN-C		educated on 07/06/23 on co	mpleting		
		can clean it, and if a nurse		orders for cleaning tube fee	•		
	notices it, they sho	uld clean it.		cleaning air filters for the ox	,		
		· · · · · · · · · · · · · · · · · · ·		concentrators by DON. The			
		on 6/1/23 at 11:08 a.m.,		designee will audit cleaning			
		NA)-D stated staff are		feeding poles 3x/week for 4	•		
		a TELS (software program for ests) request when things need		weekly for 8 weeks, and the ensure continued compliance	•		
	•	D stated you can access the		and/or designee will audit w			
	•	e dashboard when logging		of air filters for the oxygen c	,		
	onto the computer.			weekly for 12 weeks and the			
				ensure continued compliand	•		

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE COMF	E SURVEY PLETED
		245320	B. WING			06/0) 01/2023
	PROVIDER OR SUPPLIER	CARE CENTER		2060 UPPER 55TH S	STREET EAST EIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 921	11:48 a.m., the dire the radiator (in R46 wall and loose. He is R46's bed about a was in need of repartix it. The director of supposed to put in a something needs to just tell him about it TELS system and he can't remember ever During an interview director of nursing (expect the nurse who was nurse that noticed it The DON stated shourses to change the oxygen concentrated tubing. The operation many AirSep oxygen concentrated tubing.	con and interview on 6/1/23 at ctor of maintenance verified is room), was coming off the further stated he had fixed week ago, noticed the radiator in but forgot to come back and f maintenance stated staff are a TELS request when be repaired but they will often instead of putting it in the le may forget about it stating "lerything." on 6/1/23 at 12:43 p.m. the DON) stated she would no was hanging the formula to be checking the pole and clean. She further stated any was dirty, should clean it. It is ewould also expect the lefilters in the residents ors when they change the centrator (undated) indicated ke gross particle filter was a of the unit and should be ek.	F 9	3. As part of V Living ongoing assurance, the	Voodlyn Heights Seni g commitment to qual e DON and/or designed ed concerns through to QA Process.	ity ee will	

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PRINTED: 08/02/2023 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION 11 - MAIN BUILDING 01	` ′	TE SURVEY MPLETED
		245320	B. WING			06	/01/2023
	PROVIDER OR SUPPLIER			20	REET ADDRESS, CITY, STATE, ZIP CODE 160 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	KC	000			
	FIRE SAFETY						
	conducted by the National Public Safety, State June 01, 2023. At the Woodlyn Heights is not in compliance with participation in Med Subpart 483.70(a), 2012 edition of National Association (NFPA Chapter 19 Existing edition of NFPA 99). THE FACILITY'S PALLEGATION OF COMPARTMENT'S ASSIGNATURE AT THE PAGE OF THE CMUSED AS VERIFICATION OF CONSITE REVISIT CONDUCTED TO SUBSTANTIAL COREGULATIONS HASCORDANCE WITH CORRECTION FOR DEFICIENCIES (KAIFFICIENCIES).	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. THE PLAN OF R THE FIRE SAFETY -TAGS) TO: S IN THE E-POC PROCESS, A THE PLAN OF CORRECTION					
_ABORATOR`	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE
Electron	ically Signed						07/07/2023

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245320	B. WING	1	06/	01/2023
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO. 1. A detailed described taken or planned to 2. Address the metaplace to ensure the 3. Indicate how the future performance sustained. 4. Identify who is reactions and monitor 5. The actual or performance of the remedy. The Woodlyn Height 2-story building with was built in 1973 are Type II(111) construated to be of building is fully fire a fire alarm system we detection and space.	pections Division Suite 145 -5145, OR @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: ription of the corrective action correct the deficiency. easures that will be put in deficiency does not reoccur. e facility plans to monitor to ensure solutions are				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245320	B. WING		06/01/2023
	PROVIDER OR SUPPLIER	CARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
K 000	Continued From pa	ge 2	K 000		
	The facility has a cacensus of 65 at the	apacity of 79 beds and had a time of the survey.			
	The requirement at NOT MET as evide	42 CFR, Subpart 483.70(a) is need by:			
	Sprinkler System - CFR(s): NFPA 101	Maintenance and Testing	K 353		6/30/23
	Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspermental and in a section available.	Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, aining of Water-based Fire a. Records of system design, ection and testing are cure location and readily system last checked			
	b) Who provided s	system test			
	any non-required of system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMENT by: Based on observation facility failed to main NFPA 101 (2012 expection 9.7.5, and New York 10.10 (2012).	KS information on coverage for r partial automatic sprinkler and NFPA 25 NT is not met as evidenced tion and staff interviews, the ntain Sprinkler System per dition), Life Safety Code NFPA 25 2011 section		K 353 PLAN OF CORRECTION Woodlyn Heights Senior Living denie violated any federal or state regulation	ons.
		cient finding could have a on the residents within the		Accordingly, this plan of correction do not constitute an admission or agree by the provider to the accuracy of the facts alleged or conclusions set forth	ement e

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245320	B. WING _		06/0	01/2023
	PROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
K 353	observation that the have been in service replaced or represe more sample areas	0:00 AM, it was revealed by facility has fire sprinklers to for 50 years, they shall be entative samples from one or	K 35	the statement of deficiencies. The corrections is prepared and/or exe solely because it is required by the provisions of federal and state law Completion dates are provided for procedural processing purposes a correlation with the most recently completed or accomplished correction and do not correspond chronologically to the date the faci maintains it is in compliance with the requirements of participation, or the corrective action was necessary. 1. In continuing compliance with K 353, Sprinkler System – Mainter and Testing. Woodlyn Heights Ser Living Facility corrected the deficiency and the sprinklers will not go beyond their life and will be replaced prior. 2. To correct the deficiency and to the problem does not recur staff we educated on 7/6 and 7/7 on Life S Jeffery Treitline. The Maintenance Director and/or designee will audit replacement sprinklers and includ documentation in TELS (Woodlyn Preventative Maintenance Documentation) and the Life Safe Manual. 3. As part of Woodlyn Heights Ser Living ongoing commitment to qua assurance, the Maintenance Direction and/or designee will report identific concerns through the community's Process.	cuted characteristics and ctive lity he nance nor ency by all 50 year cere afety by the e Heights ty nior ality ctor ed	

`` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245320	B. WING _		06/01/2023	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.47	
K 712	Fire Drills Fire drills include the signal and simulation conditions. Fire drill unexpected times used to least quarterly on ewith procedures and established routine between 9:00 PM announcement may alarms. 19.7.1.4 through 19.7.1.4 through 19.7.1.4 through 19.7.1.4 through 19.7.1.4 through 19.7.1.5 REQUIREMENTS Based on a review and staff interview, Fire drills per NFPA Safety Code, section This deficient finding impact on the resident findings include: On 06/01/2023 at 0.0000.	ne transmission of a fire alarm on of emergency fire ls are held at expected and under varying conditions, at ach shift. The staff is familiar d is aware that drills are part of the work	K 71:	2	ons. oes ement e n in an of	
	shafts, 2nd quarter shifts, and 4th quar under new manage. An interview with Fallowship in the shafts of the shaf	for the 1st quarter of 2023, all and shaft, 3rd quarter, all ter, all shifts. The facility is ment as of April 2023. Cacility Director verified this the time of discovery.		solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	/e /	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245320	B. WING			06/0	01/2023
	PROVIDER OR SUPPLIER	CARE CENTER	•	20	TREET ADDRESS, CITY, STATE, ZIP CODE 060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 712	Continued From pa	ge 5		12	1. In continuing compliance with K 712, Fire Drills. The Woodlyn He Senior Living Facility corrected the deficiency by conducting monthly drequired by the state. 2. To correct the deficiency and to the problem does not recur staff we educated on 7/6 on fire drills by Jet Treitline. The Maintenance Director designee will audit the Life Safety requirements during the monthly sameeting and include documentation TELS (Woodlyn Heights Preventati Maintenance Documentation) and Safety Manual. 3. As part of Woodlyn Heights Sent Living ongoing commitment to qual assurance, the Maintenance Direct and/or designee will report identified concerns through the community's Process.	rills as ensure fery and/or afety n in ve the Life or ity or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00829	B. WING		C 06/01/2023	
			TATE 710 000E	1 00/01/2023	
NAME OF PROVIDER OR SUPPLIER	2060 UPP	PER 55TH ST	TATE, ZIP CODE REET EAST		
WOODLYN HEIGHTS HEALTH	ICARE CENTER		TS, MN 55077		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
2 000 Initial Comments		2 000			
****ATTE	NTION*****				
NH LICENSING	CORRECTION ORDER				
144A.10, this correspond to a survey found that the deficient are not corrected shall with a schedule of the Minnesota Deputermination of we corrected requires requirements of the number and MN R	Minnesota Statute, section ection order has been issued by. If, upon reinspection, it is ciency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of eartment of Health. The hether a violation has been compliance with all e rule provided at the tagule number indicated below. Ins several items, failure to				
comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.					
that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance.				
was conducted consurveyors from the Health (MDH). In a investigations were Healthcare Center	TS: 23, a standard licensing survey impleted at your facility by Minnesota Department of ddition, multiple complaint completed. Woodlyn Heights was found not in compliance Licensure, and the following				

Minnesota Department of Health

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

(X6) DATE

TITLE

Electronically Signed

07/08/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	1 ` ′	(X3) DATE SURVEY COMPLETED		
		00829	B. WING			C 01/2023
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UP	DDRESS, CITY, ST PER 55TH STF ROVE HEIGHT	REET EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From pa		2 000			
	The following comp the survey:	laints were reviewed during				
	issued at 0960, 166 H53202432C (MN8	6824); with licensing orders 55, and 0915 7567) 7589); with licensing order 9667)				
	correction that you	our electronic plan of have reviewed these orders, when they will be completed.	•			
	Correction Orders to numbers have been statutes/rules for Notag number appears "ID Prefix Tag." The compliance is listed of Deficiencies" column also include violation of the state "This Rule is not me the surveyor's find Method of Correction. You have agreed to receipt of State lice the Minnesota Departments.	ing the State Licensing using Federal software. Tag in assigned to Minnesota state ursing Homes. The assigned is in the far left column entitled is in the far left column entitled in the "Summary Statement umn and replaces the "To the correction order. This is the findings which are in it is statute after the statement, it is existence by." Following ings are the Suggested on and Time Period for participate in the electronic insure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/inf				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00829	B. WING			C 01/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
WOODLY	N HEIGHTS HEALTH	CARE CENTER	ER 55TH ST ROVE HEIGH	REET EAST TS, MN 55077			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
	delineated on the at Department of Heal you electronically. It is necessary for State enter the word "CO available for text. You electronic State lice heading completion be corrected prior to the Minnesota Depais enrolled in ePOC not required at the state form. PLEASE DISREGATE FOURTH COLUMN "PROVIDER'S PLATES TO FEDE THIS WILL APPEAR	e licensing orders are stached Minnesota of the orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the date, the date your orders will be electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of RD THE HEADING OF THE	2 890			7/6/23	
	that is directed towarthrough positioning implemented and more comprehensive resident of nursing services development of a nursing services that:	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which the enters the nursing home age of motion does not on in range of motion unless all condition demonstrates range of motion is					

Minnesota Department of Health

STATE FORM OI2O11 If continuation sheet 3 of 28

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00829	B. WING		C 06/01/2023
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, MN 55077	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
2 890	Continued From pa	ge 3	2 890		
	by: Based on observati review the facility fa motion to one of on	ent is not met as evidenced on, interview and document iled to provide range of e resident (R2) reviewed for o had limited range of motion mities.		corrected	
	Findings include:				
	3/3/23, indicated R2 needed extensive a dressing, toileting, a totally dependent or lift (an assistive devicannot transfer on the second secon	num Data Set (MDS), dated was cognitively intact and essistance with bed mobility, and personal hygiene and was a staff for transfers via a Hoyer vice that allows residents who sheir own be transferred a chair using electrical or			
	diagnosis of multipl	osis list indicated R2 had a e sclerosis (a potentially f the brain and spinal cord).			
	a nursing rehabilitat	ed 12/23/23, indicated R2 had tion program for passive range ateral upper extremities once ing instructions:			
	7. Elbow close to be abdomen	ach fingertip part then together n			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00829	B. WING		06/0	C 01/2023
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	REET EAST ITS, MN 55077	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT) CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 890	shoulder height. R2's nursing assists medical record (EM range of motion (R0 upper extremities or instructions: 1. Fing Thumb touch to each apart then together up, then palm down shoulder, then straighody, rotate hand or arm, with thumb up Left arm, thumb up Left arm, thumb up shoulder height. R2 indicated the facility program six (6) time. During an interview occupational therap upper extremity ran further confirmed structure and interview nursing assistant (Nof a ROM program it herself." NA-C fur refuse cares. During an interview director of nursing (aware of a ROM program it herself." The DOM care plan, the expecompleted.	ge 4 up, assist to extend arm up to ant (NA) tasks in the electronic (R) indicated R2 had a passive (DM) program to her bilateral nce daily with the following ters into a fist, then out 2. ch fingertip 3. fingers spread 4. wrist up and down 5. Palm totation 6. Palm up- touch ghten elbow 7. Elbow close to ut and to abdomen 8. Right totation arm to face height 9. the stask documentation to NAs had completed the ROM tes in the past 30 days. on 5/31/23 at 1:53 p.m., to posit (OT)-A stated R2 was on the ge of motion program and that had not been completing on 6/1/23 at 7:16 a.m., NA)-C stated he was unaware for R2 and stated, "she can do ther stated R2 does not often on 6/1/23 at 9:33 a.m., the (DON) stated she was not form for R2 and if she was N further stated if it was on the ctation was for it to be				
	received.					

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Minnesota Department of Health STATE FORM

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l `´	E CONSTRUCTION	COMPLETED		
		00829	B. WING			C 01/2023
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/0	
		2060 UPP		REET EAST		
WOODLY	/N HEIGHTS HEALTH	INVER GF	ROVE HEIGH	ITS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INCOMPAGE OF THE APPROPERT	D BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 5	2 890			
	SUGGESTED MET The director of nurs review applicable per range-of-motion (Re and completed time staff and audit to er TIME PERIOD FOR (21) days MN Rule 4658.0525	HOD OF CORRECTION: sing (DON), or designee, could	2 900			7/6/23
	comprehensive resident values of nursing services development of a nursides that: A. a resident who without pressure sores unleaded to a nurside the sores un					
	by: Based on observation review the facility facility and admitted without a page 1.	ent is not met as evidenced on, interview, and record iled to ensure a resident pressure injury did not develop hile in the facility and failed to		corrected		

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00829	B. WING		1) 1/2023
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UPP	ER 55TH ST	REET EAST ITS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	healing of pressure resident (R2) review Findings include: R2's quarterly Mining 3/3/23, indicated R2 needed extensive a dressing, toileting, a totally dependent or lift (an assistive devicannot transfer on the between a bed and hydraulic power). Thad a stage IV, facility	nterventions for prevention and injuries for one of one wed for pressure injuries. num Data Set (MDS), dated was cognitively intact and assistance with bed mobility, and personal hygiene and was a staff for transfers via a Hoyer wice that allows residents who sheir own be transferred a chair using electrical or he MDS further indicated R2 lity acquired pressure injury on an wound on the tailbone with a loss with exposed bone,	2 900			

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00829	B. WING		06/0) 1/2023
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UPP	ER 55TH ST	REET EAST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 7	2 900			
	-	m., R2 was out of bed, sitting ithout staff offering to transfer tion her.				
		on 5/31/23 at 8:13 a.m., R2 air in the dining room eating				
		on 5/31/23 at 8:47 a.m., R2 air in the dining room, done sitting alone.				
	was brought back to	on 5/31/23 at 8:50 a.m., R2 her room via her wheelchair her room in her wheelchair.				
	facility staff entered intravenous medica	on 5/31/23 at 9:11 a.m., R2's room to set up her tions but did not offer to I or help her shift positions in				
		on 5/31/23 at 9:53 a.m., R2 ting in her wheelchair.				
		on 5/31/23 at 10:40 a.m., R2 ting in her wheelchair.				
	was in her room, sit	on 5/31/23 at 11:42 a.m., R2 ting in her wheelchair. A IA) entered to take R2 out to chair.				
		on 5/31/23 at 12:53 p.m., R2 nch, sitting in her wheelchair m.				
	1:00 p.m., R2 was I	and interview on 5/31/23 at aid down in bed via a Hoyer ilbone area was sore and that				

1 ` ′	VIDER/SUPPLIER/CLIA ITIFICATION NUMBER:	1 ` '		(X3) DATE SURVEY COMPLETED	
00	829	B. WING			C 01/2023
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CI	ENTER 2060 UPP	ER 55TH STE	TATE, ZIP CODE REET EAST TS, MN 55077		
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APPOPULATION DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
the longer she sat up in her it hurt. R2 further stated fac to transfer her to bed betwe lunch. During an interview on 6/1/2 stated R2 needed assistant activities of daily living (ADL nursing assistants get R2 up breakfast and lay her back of lunch. NA-C stated facility on R2 down between breakfast does not often refuse cares. During an interview on 6/1/2 registered nurse (RN)-B stated familiar with R2's cares. RN sheet which RN-B confirme information on how often to further reviewed R2's medic record (MAR) which indicate her wheelchair for meals on During an interview on 5/31. occupational therapist (OT)-have a physician order to on wheelchair for meals due to on her sacrum. OT-A furthe importance of this because appropriate for her as it does support she needs. During an interview on 6/1/2 director of nursing (DON) strefuses cares or to be repose confirmed there were no introduced and that the EMR lacked do refusals. The DON further strengths and that the EMR lacked do refusals. The DON further strengths and that the EMR lacked do refusals. The DON further strengths are stated factors.	en breakfast and 23 at 7:16 a.m., NA-C be from staff with all as). NA-C stated the prin her chair before down in bed after taff do not offer to lay and lunch and R2 from facility staff. 23 at 7:23 a.m., ted she was not lacked any reposition R2. RN-B beation administration and R2 was to be up in ally. 23 at 1:53 p.m., A stated R2 does ally be in her at the pressure injury restated the R2's wheelchair is not as not give her the restated that R2 often sitioned. The DON erventions in place to sals for repositioning ocumentation of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00829	B. WING		C 06/01/2023	
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALT	HCARE CENTER 2060 UPP	ER 55TH ST	REET EAST TS, MN 55077		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
facility acquired pressure injuries in stated they do not manage R2's pressure know what else with A policy on pressure not received. SUGGESTED MET The director of nureview applicable and comprehensing ulcer needs, inclusion completed and impressure in the state of the state o	to promote healing of her ressure injury or to prevent new form developing. The DON have a proactive plan to ssure injuries stating, "I don't	2 900			
TIME PERIOD FO (21) days	OR CORRECTION: Twenty-one 25 Subp. 6 A Rehab - ADLs	2 915		7/6/23	
Subp. 6. Activities comprehensive rehame must ensure A. a resident treatments and seabilities in activities deterioration is a the resident's compart, activities of contesting the resident's ability to (1) bathe, dresident activities of (1) bathe, dresident activities of (2) bathe, dresident activities of (3) bathe, dresident activities of (4) bathe, dresident activities of (5) bathe, dresident activities of (6) bathe, dresident activities activi	s of daily living. Based on the sident assessment, a nursing e that: s given the appropriate ervices to maintain or improve s of daily living unless normal or characteristic part of dition. For purposes of this laily living includes the or company includes the or compan				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SU COMPLET				
		00829	B. WING		06/0) 1/2023
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPF	PER 55TH ST	STATE, ZIP CODE REET EAST ITS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 915		ge 10 n, language, or other cation systems; and	2 915			
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview and document ailed to provide routine baths he for one of one residents activities of daily living		corrected		
	dated 5/14/23, indicinated and needed et transfers, bed mobile	Alinimum Data Set (MDS), eated R267 was cognitively extensive assistance with lity, locomotion on and off the oilet use and limited sonal hygiene.				
	several medical dia	gnosis list indicated R267 had gnoses including severe ase and acquired absence of nee.				
	interventions to ass bathing and indicate staff member for dr	ated 5/8/23, lacked any ist R267 with showering or ed R267 needed assist of one essing/undressing and eting and occasional des.				
		electronic medical record 267 received one bath, on ssion on 5/8/23.				

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED	
		00829	B. WING			C 01/2023	
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	REET EAST ITS, MN 55077			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 915	Continued From pa	ge 11	2 915				
	7:35 a.m., R267 sta since she was adm "they just kind of sk bath". R267 was we pajama shirt and lig	and observation on 5/30/23 at ted she had one bed bath itted to the facility and stated, ip over me when it's time for a earing a grey, button-down the pink shorts. R267's hair and matted down in the					
	R267 was wearing	on 5/30/23 at 11:09 a.m., the same grey, button-down ht pink shorts as that					
	9:18 a.m., R267 was button-down pajam 5/30/23. R267 state any personal hygier stated, "I couldn't ev	and interview on 5/31/23 at s wearing the same grey, a shirt and light pink shorts as d nobody had helped her with he that morning and further wen wash my face because he washcloths or towels".					
	2:03 p.m., R267 was	d observation on 5/31/23 at sout in the facility hallway, had been in the same clothes II had not received any ls to wash up with.					
	8:30 a.m., R267 wa	and interview on 6/1/23 at s wearing the same grey, a shirt from 5/30/23.					
	nursing assistant (Nardex to know who NA-B further stated the nurse's station and day was Sunday even	on 5/31/23 at 9:42 a.m., IA)-B stated the NAs use the at cares to provide a resident. there was a bath schedule at and confirmed R267's bath enings. NA-B also confirmed nented when a bath was given					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D MINIO			
		00829	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER /N HEIGHTS HEALTH	CARE CENTER 2060 UPP	ER 55TH ST	REET EAST		
				TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 12	2 915			
		EMR. NA-B stated R267 does t could be particular on the				
	registered nurse (R that baths or showe they were schedule occasionally will get	on 6/1/23 at 8:08 a.m., N)-A stated it was expected ers were completed the day d. RN- A stated she t notified if a bath or shower is as to ask if they were				
	director of nursing (on 6/1/23 at 9:33 a.m., the DON) stated the expectation d baths to be completed the duled.				
	A policy on ADLs wa	as requested but not received.				
	The director of nurse review applicable per and grooming cares	HOD OF CORRECTION: sing (DON), or designee, could olicies on ensuring hygiene s are provided timely; then staff and audit to ensure				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
2 960	MN Rule 4658.0600 Food Quality	Subp. 1 Dietary Service -	2 960			7/7/23
	•	uality. Food must have taste, ance that encourages resident d.				

	I OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00829	B. WING		06/0	; 1/2023
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETE DATE
2 960	by: Based on observation review the facility fac	ent is not met as evidenced on, interview and document iled to ensure food was latable temperatures for 3 of 3 5, and R267) who were yed and/or complained about		corrected		
	dining room the foo	d would be hotter". DM-A /ays have enough staff" to				
	R46 R46's quarterly MD had intact cognition	S dated 5/11/23, indicted R46				
	stated, "food sucks' sure" most of the tir has refused "hot pla cold". R46 stated th	5/30/23 at 7:29 a.m., R46 ', and warm food is "cold for ne it is served. R46 stated she ate stuff" because it is "always e facility staff were aware of o solutions were offered.				

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
		00829	B. WING		1) 1/ 2023
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	REET EAST ITS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 960	Continued From pa	ge 14	2 960			
	8:18 a.m., dietary a room with a breakfacereal, carton of mi pieces of toast and asked surveyor to the show how warm they were cool to the trays should be sere assistants and dietal should be helping under the same "a lot of the resident "plated downstairs a here finally". NA-A saware and their residents to eat their rooms. NA-A saware rooms. NA-A saware and their rooms.	ion and interview on 5/30/23 at ide (DA)-B entered R46's ast tray that included a bowl of lk, two sausage links, two one hard-boiled egg. R46 ouch the sausage links to ey were. DA-B acknowledged are touch. DA-B stated the food wed by both the nursing ary aides, however the "aides is but don't". The nursing assistant (NA)-A on a., NA-A stated she had was complaints of cold food from ts". NA-A stated the food is and is cold when arrives up stated facility management is ponse is to encourage all of in the dining room instead of stated nursing assistants " are trays often as kitchen will say				
	R267 R267's Admissions R267 had intact cog	MDS dated 5/14/23, indicated gnition.				
		th R267 on 5/30/23 at 7:47 most of the time the food is				
	a.m., R267 stated,	th R267 on 5/31/23 at 9:24 "I just ate cold cereal for cause the hot food is always ets to me".				
		th DA-A on 5/31/23 at 8:10 residents do tell me that their				

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
		00829	B. WING			C 01/2023	
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UF	ADDRESS, CITY, S PPER 55TH STI GROVE HEIGH	REET EAST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 960	During interview with 8:23 a.m., C-A state to pass trays. "the figets to the resident help to pass the trans." During interview with (LPN)-A on 5/31/23 know the food is not they (residents) get trays when we are plights." During interview with a.m., DM-A stated the needs of the residents do not was to eat meals in the food to eat meals in the food is not was to eat meals in the food is not was to eat meals in the food is not was to eat meals in the food is not was to eat meals in the food is not was to eat meals in the food is not was to eat meals in the food is not was to eat meals in the food is not was to eat meals in the food is not was to eat meals in the food is not was to eat meals in the food is not was to eat meals in the food is not was to eat meals in the food is not was the food is not was to eat meals in the food is not was to eat	rd when I am the only one lo one wants to help". The cook (C)-A on 5/31/23 at led there was not enough staff lood is ice cold by the time it is because we don't have the					
	at 6:18 a.m., the ad temperature complete The administrator set a plan to arrange far before meal service much success. The dietary aides and not responsible for passible for	th the administrator on 6/1/23 ministrator stated the food aints is an "on-going issue". Itated the facility implemented cility activities immediately but that has not met with administrator stated the ursing assistants are sing meal trays and the do not help as much as they istrator stated, "yes, the					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		00829	B. WING			C 01/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	<u>, </u>	
WOODLY	YN HEIGHTS HEALTH	CARE CENTER	ER 55TH ST ROVE HEIGH	REET EAST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 960	Continued From pa	ge 16	2 960			
	residents are getting being passed out".	g cold food when the trays are				
	The administrator, of applicable practices delivery of meal tray	HOD OF CORRECTION: or designee, could review and policies on timely ys to ensure palatable tained; then educate direct to ensure ongoing				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			7/6/23
	must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adea D. in the present which indicate the discontinued. In addition to the discontinued. In addition to the discontinued the part 4658.1310, the with provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Face	al. A resident's drug regimen innecessary drugs. An sany drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply the Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the Ith and Human Services,				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			, 20.22			;	
		00829	B. WING		06/0	1/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
WOODL	YN HEIGHTS HEALTH	CARE CENTER		REET EAST			
040.15	CLIMANA DV CTA			TS, MN 55077		0.(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOULD SHO	D BE	(X5) COMPLETE DATE	
21535	Continued From pa	ge 17	21535				
	This standard is included available through the	ing Administration, April 1992. orporated by reference. It is e Minitex interlibrary loan te Law Library. It is not change.					
	by: Based on observation review, the facility fa	al interventions were		corrected			
	Findings include:						
	2/14/23, identified Formatted no de and required extens activities of daily living MDS outlined R46 in PRN pain medication however, did not reintervention for pain	imum Data Set (MDS), dated R46 had intact cognition, elusional thinking or beliefs, sive assistance with several ng (ADLs). In addition, the received both scheduled and ons during the review; ceive any non-medication a. Further, R46 indicated they which they rated at eight (8) out worst possible).					
	had actual pain with management and li- interruption in norm The care plan listed meet this goal whice	ted 3/11/23, identified R46 needing medication sted a goal, "Will not have an al activities due to pain" I interventions to help R46 h included, "Offer al interventions for pain relief					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		00829	B. WING			C 01/2023
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPF	DDRESS, CITY, ST PER 55TH STE ROVE HEIGH	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21535	R46's Order Summidentified R46's curmedications and treorders for acetamina 1000 milligrams (minaddition, twice a canarcotic pain metimes a day PRN for corresponding Med (MAR), dated 4/202 ordered medication demonstrate adminada a total of 12 do administered over trincluding the following the fo	positioning, massage[,] etc." ary Report, dated 5/1/23, rent physician-ordered eatments. This included active tophen (a mild pain reliever) g) twice a day scheduled and, day PRN for pain; and Norco dication) 5-325 mg up to three or "severe pain." R46's ication Administration Records 3 and 5/2023, identified R46's s with corresponding initials to istration. This identified R46 ses of the PRN Norco he previous two month perioding: a.m., with R46 rating their e results being listed as, sponding progress note, dated e medication was given with aptoms recorded; nor what, if logical interventions were d prior to administration. a.m., with R46 rating their e results being listed as, sponding progress note, dated e medication was given with aptoms recorded; nor what, if logical interventions were d prior to administration. a.m., with R46 rating their e results being listed as, sponding progress note, dated e medication was given with aptoms recorded; nor what, if logical interventions were d prior to administration. .m., with R46 rating their pain .m., with R46 rating their pain				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY	
	00829		B. WING			C 01/2023
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UPF	DRESS, CITY, STERN STREET STRE	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOWN)	JLD BE	(X5) COMPLETE DATE
21535	On 4/5/23 at 10:08 pain at 6/10, and the "Effective." A correst 4/5/23, identified the no indication or synanother dose was pp.m., with R46 ratin results being listed again, neither of the non-pharmacologic or attempted prior to the construction of the construction	d prior to administration. a.m., with R46 rating their e results being listed as, sponding progress note, dated e medication was given with aptoms recorded. In addition, provided on 4/5/23 at 7:59 g their pain at 7/10, and the as, "Effective." However, e notes identified what, if any, al interventions were offered to administration. .m., with R46 rating their pain ults being listed as, esponding progress note, fied the medication was given a symptoms recorded; nor harmacological interventions empted prior to administration. .m., with R46 rating their pain ults being listed as, sponding progress note, dated the medication was given with aptoms recorded; nor what, if logical interventions were diprior to administration. 4 p.m., with R46 rating their e results being listed as, sponding progress note, dated the medication was given with aptoms recorded; nor what, if logical interventions were diprior to administration. 4 p.m., with R46 rating their e results being listed as, sponding progress note, dated the medication was given with aptoms recorded; nor what, if logical interventions were diprior to administration. .m., with R46 rating their pain with R46 rating their pain logical interventions were diprior to administration.	21535			

Minnesota Department of Health

STATE FORM OI2O11 If continuation sheet 20 of 28

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	` ′	E SURVEY PLETED
	00829	B. WING			C 01/2023
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTH	ICARE CENTER 2060 UPP	ER 55TH STF	TATE, ZIP CODE REET EAST TS, MN 55077		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
5/4/23, identified the no indication or synany, non-pharmacon offered or attempted. R46's medical reconstructions were the administration for nearly all of the 4/1/23 to 5/30/23. On 5/31/23 at 8:02 laying in bed while comfortable and we symptoms of pain was interviewed and many medications seemed to have an take. R46 stated the severe pain due to migraines; and experimental when acetaminophy control it. R46 stated time in recent more non-pharmacological to giving Norco; however what, if any interventions may when interviewed nursing assistant (an "extensive amonand, at times, would knees from arthritistit," and explained the stated if R46 complain about he stated if R46 complain about he stated if R46 complain.	sponding progress note, dated the medication was given with imptoms recorded; nor what, if ological interventions were ed prior to administration. Ord was reviewed and lacked of any, non-pharmacological offered or attempted prior to of the PRN narcotic medication administered doses from a.m., R46 was observed in their room. R46 appeared in their room. R46 appear				

MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077 WAND AND AND AND AND AND AND AND AND AND	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE	SURVEY PLETED	
WOODLYN HEIGHTS HEALTHCARE CENTER CAPID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL (EACH DEFICIENCY MUST BE PRECEDED BY FILL (EACH DEFICIENCY MUST BE PRECEDED BY FILL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE DT OTHE APPROPRIATE DATE 21535 Continued From page 21 21535			00829	B. WING			
PRÉÉIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 21535 Continued From page 21 address it adding the aides, including themselves, had never been directed or asked to attempt ice or heat packs or other non-pharmacological interventions with R46 in the prior months. During interview on 5/31/23 at 10:16 a.m., registered nurse (RN)-A stated R46 was "mostly bed bound" and would verbally ask for most things, including PRN narcotics, to R46, and RN-A verified R46 had orders for the PRN Norco in place since 2021 according to the medication, including part and document any non-pharmacological interventions offered or completed prior to the medication being given in a progress note. RN-A expressed this was important to do as staff "want to try everything we can before giving medication," adding further, "[I know] documentation is big." On 5/31/23 at 12:35 p.m., registered nurse unit manager (RN)-B was interviewed and verified they had reviewed R46's medical record. RN-B explained through listed which			CARE CENTER 2060 UPP	ER 55TH ST	REET EAST	-	
address it adding the aides, including themselves, had never been directed or asked to attempt ice or heat packs or other non-pharmacological interventions with R46 in the prior months. During interview on 5/31/23 at 10:16 a.m., registered nurse (RN)-A stated R46 was "mostly bed bound" and would verbally ask for most things, including pain medication, when needed. RN-A stated R46's unit often had a trained medication aide (TMA) working and passing the medications, including PRN narcotics, to R46, and RN-A verified R46 had orders for the PRN Norco in place since 2021 according to the medical record. RN-A explained the process for providing PRN medication, including narcotics, should include an assessment of the issue and staff should "definitely" attempt and document any non-pharmacological interventions offered or completed prior to the medication being given in a progress note. RN-A expressed this was important to do as staff "want to try everything we can before giving medication," adding further, "[I know] documentation is big." On 5/31/23 at 12:35 p.m., registered nurse unit manager (RN)-B was interviewed and verified they had reviewed R46's medical record. RN-B explained R46's care plan had non-pharmacological interventions listed which	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETE
all PRN narcotic administrations, however, there was no evidence the interventions were attempted or offered in the medical record with each administration adding, "I am not seeing any." RN-B verified staff were supposed to attempt and document their non-pharmacological approaches prior to giving PRN medication	21535	address it adding the had never been dire or heat packs or oth interventions with R. During interview on registered nurse (R. bed bound" and wo things, including part RN-A stated R46's medication aide (TN medications, including and RN-A verified R. Norco in place sincomedical record. RN providing PRN medications and record in place sincomedical record. RN providing PRN medications and record in place sincomedical record. RN providing PRN medications and record in place sincomedical record. RN providing PRN medications and record in place sincomedical record. RN providing PRN medications and record in place sincomedical record. RN providing PRN medications and record in place sincompleted prior to the progress note. RN-important to do as sincompleted prior to the progress note.	the aides, including themselves, ected or asked to attempt ice her non-pharmacological (46 in the prior months.) 5/31/23 at 10:16 a.m., N)-A stated R46 was "mostly uld verbally ask for most in medication, when needed. Unit often had a trained (MA) working and passing the ing PRN narcotics, to R46, (46 had orders for the PRN (46 had orders for the PRN (48 the explained the process for ication, including narcotics, ssessment of the issue and ely" attempt and document ogical interventions offered or he medication being given in a A expressed this was staff "want to try everything we hedication," adding further, "[I on is big." 5 p.m., registered nurse unit as interviewed and verified (R46's medical record. RN-B re plan had al interventions listed which mpting and documenting with ministrations, however, there is interventions were d in the medical record with adding, "I am not seeing staff were supposed to ent their non-pharmacological				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE	SURVEY
		00829	B. WING			C 01/2023
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UPP	ER 55TH ST	TATE, ZIP CODE REET EAST TS, MN 55077		
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21535	the administration of narcotics could cau R267's admission of dated 5/14/23, indicitated and needed eseveral ADLs. R267's Physician OR267 had an order pain medication) five four (4) hours PRN R267's care plan, deserting medication manages of such as musically as musically as the such	al approaches to help "reduce of medication," and they added se potential addiction. Minimum Data Set (MDS), cated R267 was cognitively extensive assistance with orders, dated 5/8/23, indicated for Oxycodone (a narcotic e (5) milligrams (mg) every (as needed) for severe pain. ated 5/8/23, indicated R267 all for pain with need for ement, with an intervention to ological interventions for pain c, repositioning, massage etc". ecord, dated 5/8/23, indicated serve pain every shift and all and/or non-verbal indicators ations, including all interventions in a pain administration record elived PRN Oxycodone on as since admission to the cluding the following: .m., with a documented pain alle of one (1)-10. p.m., with a documented pain	21535			
		p.m., with a documented pain le of one (1)-10 and on 11:41				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
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	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPF	PER 55TH ST	TATE, ZIP CODE REET EAST TS, MN 55077		
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21535	on 5/17/12 at 8:27 rating of 7 on a scap.m., with a docume scale of one (1)-10. On 5/18/23 at 5:29 rating of 5 on a scawith a documented one (1)-10. On 5/19/23 at 11:27 pain rating of 6 on a construction of 5 on a scawith a documented one (1)-10. On 5/19/23 at 11:27 pain rating of 6 on a construction of 6 on a construction of 7 on a scawhat, if any, non-phase what, if any, non-phase offered or attended in the construction of pain. During an interview registered nurse (Registered nurse (Registered nurse (Registered nurse) (Registered nu	p.m., with a documented pain le of one (1)-10 and 11:58 ented pain rating of 3 on a a.m., with a documented pain le of one (1)-10 and 6:13 p.m., pain rating of 7 on a scale of 7 p.m., with a documented a scale of one (1)-10. 5 a.m., with a documented a scale of one (1)-10. 5 a.m., with a documented pain p.m., with a documented pain p.m., with a documented pain				

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	COMPLETED	
		00829	B. WING		06/0	; 1/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WOODLYN	N HEIGHTS HEALTH	CARE CENTER		REET EAST ITS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICITIES (CORRECTION CORRECTION)	D BE	(X5) COMPLETE DATE
21535	Continued From pag	ge 24	21535			
t	reviewed R267's pro	r each resident. RN-A ogress notes and confirmed mented pain assessments or armacological pain				
i r r	director of nursing (was for nurses to of nterventions for paid non-pharmacological planned but nurses	on 6/1/23 at 9:33 a.m., the DON) stated the expectation fer non-pharmacological n. The DON confirmed al pain interventions were care were not documenting if any al pain interventions were d.				
	consulting pharmac expectation was for document all non-pl	staff to attempt and harmacological interventions administration. CP added, "It's				
r	The director of nurs review applicable pondon-pharmacological and recorded prior the second (PRN) not be as-needed (PRN) in the second prior the second (PRN) in the second prior the second prior the second (PRN) in the second prior the second p	al interventions are attempted to the administration of arcotic medications; then staff and audit to ensure				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
21665	MN Rule 4658.1400	Physical Environment	21665			7/6/23
	A nursing home mu	ıst provide a safe, clean,				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLE	ETE
21665	environment, allowi	ge 25 able, and homelike physical ng the resident to use to the extent possible.	21665			
	by: Based on observati review the facility fa functional, and sani	ent is not met as evidenced on, interview, and record iled to ensure a safe, tary living environment for 3 of 52, R54), reviewed for erns.		corrected		
	Findings include:					
	7:33 a.m., R46 had along the bottom of to the bed. The radiaway from the wall	and interview on 5/30/23 at a brown-colored radiator the wall on the right side next ator was pulled several inches and was loose. R46 stated the nat way for about a month and it would be fixed.				
	laying in bed received tube. The bottom of with a copious amo	on 5/30/23 at a.m., R52 was ing nutrition through a feeding the pole was visibly soiled unt of light-brown splattering ich was dry to appearance				
	10:47 a.m., R54 was receiving oxygen from concentrator. The first concentrator was concentrator was concentrated "I don't know when or how often see the concentration of the first concentration was concentrated as a stated to the concentration of the concentration was concentrated as a stated to the concentration was concentrated to the concentration was concentrated as a stated to the concentration was concentrated as a stated to the concentration was a stated to the concentration was concentrated as a stated to the concentration was a stated to the con	and interview on 5/30/23 at s sitting in a chair in her room om a NewLife Elite AirSep Iter on the backside of the overed with copious and was nearly occluded. R54 what they do" in regards to staff change or clean the filter.				
	During an obsevation	on and interview on 06/01/23				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	` '	E SURVEY PLETED	
		00829	B. WING			C 01/2023
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21665	the filter on the bac (in R54's room) was nurse was responsified and filter. He furthed tube feeding pole (crusted food splatter nurse was also responsive also stated anyone notices it, they should be repaired. Nationally assistant (Nationally assistant) and interview nursing assistant (Nationally assistant) and interview of the repaired. Nationally and loose. He rediator (in R46 wall and loose. He rediator (in R46 wall and loose. He rediator of repaired about a was in need of repaired to put in something needs to just tell him about it TELS system and he can't remember even director of nursing (expect the nurse where the tube feeding making sure it was nurse that noticed in The DON stated should be a surface of the poon stated should be a surface of the surfac	tered nurse (RN)-C verified k of the oxygen concentrator is dirty and stated the night lible for changing the tubing r verified the bottom of the in R52's room) had dried and ering all over it and the night ponsible for cleaning it. RN-C can clean it, and if a nurse all clean it. I on 6/1/23 at 11:08 a.m., NA)-D stated staff are a TELS (software program for sts) request when things need D stated you can access the e dashboard when logging ion and interview on 6/1/23 at ctor of maintenance verified 's room), was coming off the further stated he had fixed the week ago, noticed the radiator air but forgot to come back and f maintenance stated staff are a TELS request when be repaired but they will often instead of putting it in the ne may forget about it stating "I				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		00829	D. WING		06/01/2023
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	REET EAST ITS, MN 55077	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
21665	The operation many AirSep oxygen conditions the external air intail located on the back unit and should be on the facility's policy was requested but a SUGGESTED MET. The administrator, of applicable policies a resident care equipal a clean, sanitary many care staff and audit compliance.	they change the tubing. ual for the NewLife Elite centrator (undated) indicated ke gross particle filter was of the cleaned once a week. regarding cleaning equipment not received. THOD OF CORRECTION: or designee, could review and practices for ensuring ment and room(s) are kept in anner; then educate direct	21665	DEFICIENCY)	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 23, 2023

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

RE: CCN: 245320

Cycle Start Date: June 1, 2023

Dear Administrator:

On July 11, 2023, we notified you a remedy was imposed. On July 14, 2023 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 July 21, 2023.

As authorized by CMS the remedy of:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective September 1, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 11, 2023, 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 September 1, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 21, 2023, 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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumala Fiske-Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 23, 2023

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

Re: Reinspection Results

Event ID: 0I2012

Dear Administrator:

On July 14, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 1, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumalu Fiske Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us