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

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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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: OI2O11

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 06/01/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/30/23 to 6/1/23, a survey for compliance with Appendix Z, the Emergency Preparedness Requirements, was completed during a standard recertification survey. Woodlyn Heights Healthcare Center was found to be in compliance with the requirements. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/30/23 to 6/1/23, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed. Woodlyn Heights Healthcare Center was found not in compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaints were reviewed during the survey: H53202430C (MN92769) H53202431C (MN86824); deficiencies issued at F676, F804, and F921. H53202432C (MN87567) H53202433C (MN87589); deficiency issued at F921. H53202434C (MN89667) H53202435C (MN89490)	F 000		

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

Electronically Signed | 07/08/2023

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.

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental	F 645		7/6/23

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

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F 645	Continued From page 3 or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level I Pre-Admission Screening (PAS) and, if needed, a Level II Pre-Admission Screening and Resident Review (PASARR) were completed, retained in the medical record, and readily available to ensure continuity of care with mental health needs for one of two residents (R48) reviewed for PASARR. Findings include: R48's admission Minimum Data Set (MDS), dated 4/19/23, indicated R48 was cognitively intact and had several medical diagnoses including anxiety, major depressive disorder, and bipolar disorder (mental illness characterized by extreme mood swings). However, the MDS indicated R48 did not have Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills) or dementia. R48's Medical Diagnosis listing, printed 6/1/23, indicated R48's current medical diagnoses were present upon admission to the facility on 4/13/23. The listing lacked any diagnosis of dementia. R48's initial Pre-Admission Screening (PAS) results, dated 4/5/23, indicated R48 was hospitalized with anticipated admission to a nursing home with an anticipated length of stay listed as "30-60 days". An attached letter from Senior Linkage Line, dated 4/5/23, indicated "The Senior Linkage Line forwarded the PAS to the county/managed care	F 645	F 645 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 645, PASARR Screening for MD & ID. Woodlyn Heights Senior Living corrected the deficiency by ensuring R48 final PASARR was in the medical record on 07/06/2023. All resident PASARRs were reviewed to ensure accurate completion on 07/06/2023 by the Executive Director. 2. To correct the deficiency and to ensure the problem does not recur the Social Workers and Medical Records were educated on the PASARR requirements on 07/06/2023 by the Executive Director.	

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F 645	Continued From page 4 organization for processing. The PAS is not final until the lead agency sends documentation to the nursing facility." The letter went on to list a lead agency and phone number for the facility to follow up with. R48's entire medical record was reviewed and lacked evidence a final determination had been received and/or evaluated by the county or managed care program as directed by the PAS (dated 4/5/23). During an interview on 5/31/23 at 11:02 a.m., the MRC stated the PAS dated 4/5/23 was for R48's most recent admission. The MRC further stated when she received the PAS, she scanned it into the computer but did not follow up with the county as the letter indicated. During an interview on 6/1/23 at 9:25 a.m., the administrator stated it was the medical records clerk's (MRC) responsibility to ensure the PAS was completed and followed up on. A policy on pre-admission screening was requested but not received.	F 645	The Executive Director and/or designee will audit 3 resident PASARRs weekly for 4 weeks, 2 resident PASARRs weekly for 4 weeks, 1 resident PASARR weekly for 4 weeks, and then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:	F 676		7/6/23

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F 676	Continued From page 5 §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine baths and personal hygiene for one of one residents (R267) reviewed for activities of daily living (ADLs). Findings include: R267's admission Minimum Data Set (MDS), dated 5/14/23, indicated R267 was cognitively	F 676	F (F676) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed	

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F 676	Continued From page 6 intact and needed extensive assistance with transfers, bed mobility, locomotion on and off the unit, dressing and toilet use and limited assistance with personal hygiene. R267's Medical Diagnosis list indicated R267 had several medical diagnoses including severe chronic kidney disease and acquired absence of left leg below the knee. R267's care plan, dated 5/8/23, lacked any interventions to assist R267 with showering or bathing and indicated R267 needed assist of one staff member for dressing/undressing and assistance with toileting and occasional 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 since she was admitted to the facility and stated, "they just kind of skip over me when it's time for a bath". R267 was wearing a grey, button-down pajama shirt and light pink shorts. R267's hair appeared disheveled and matted down in the back. During observation on 5/30/23 at 11:09 a.m., R267 was wearing the same grey, button-down pajama shirt and light pink shorts as that morning. During observation and interview on 5/31/23 at 9:18 a.m., R267 was wearing the same grey, button-down pajama shirt and light pink shorts as 5/30/23. R267 stated nobody had helped her with	F 676	solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (676), Activities of Daily Living (ADLs)/Mntn Abilities. Woodlyn Heights Senior Living corrected the deficiency by updating R267 care plan to include bathing and personal hygiene assistance and interventions on 06/29/23. All resident care plans were reviewed on 07/6/23 by DON to ensure bathing and personal hygiene assistance and interventions were addressed. 2. To correct the deficiency and to ensure the problem does not recur, all nursing staff were educated on 07/6/23 or prior to their next scheduled shift on completing routine bathing and personal hygiene cares per resident care plan by DON. All bathing schedules were added to CNA Task in POC to ensure timely completion and proper documentation by DON on 07/06/2023. 3. The DON and/or designee will audit POC documentation for completion of bathing and personal hygiene cares 3x/week for 4 weeks, then 2x/week for 8	

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F 676	Continued From page 7 any personal hygiene that morning and further stated, "I couldn't even wash my face because they did not bring me washcloths or towels". During interview and observation on 5/31/23 at 2:03 p.m., R267 was out in the facility hallway, crying, stating she had been in the same clothes since Friday and still had not received any washcloths or towels to wash up with. During observation and interview on 6/1/23 at 8:30 a.m., R267 was wearing the same grey, button-down pajama shirt from 5/30/23. During an interview on 5/31/23 at 9:42 a.m., nursing assistant (NA)-B stated the NAs use the Kardex to know what cares to provide a resident. NA-B further stated there was a bath schedule at the nurse's station and confirmed R267's bath day was Sunday evenings. NA-B also confirmed that the NAs documented when a bath was given under Tasks in the EMR. NA-B stated R267 does not refuse cares but could be particular on the timing of her cares. During an interview on 6/1/23 at 8:08 a.m., registered nurse (RN)-A stated it was expected that baths or showers were completed the day they were scheduled. RN- A stated she occasionally will get notified if a bath or shower is missed, but often has to ask if they were completed. During an interview on 6/1/23 at 9:33 a.m., the director of nursing (DON) stated the expectation was for showers and baths to be completed the day they were scheduled. A policy on ADLs was requested but not received.	F 676	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.	

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident admitted without a pressure injury did not develop a pressure injury while in the facility and failed to implement proper interventions for prevention and healing of pressure injuries for one of one resident (R2) reviewed for pressure injuries. Findings include: R2's quarterly Minimum Data Set (MDS), dated 3/3/23, indicated R2 was cognitively intact and needed extensive assistance with bed mobility, dressing, toileting, and personal hygiene and was totally dependent on staff for transfers via a Hoyer lift (an assistive device that allows residents who cannot transfer on their own be transferred between a bed and a chair using electrical or hydraulic power). The MDS further indicated R2 had a stage IV, facility acquired pressure injury on her sacrum (an open wound on the tailbone with	F 686	F (F686) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	7/6/23

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F 686	Continued From page 9 full thickness tissue loss with exposed bone, tendon, or muscle). R2's Medical Diagnosis list indicated R2 had a diagnosis of multiple sclerosis (a potentially disabling disease of the brain and spinal cord). R2's Physician orders, dated 3/19/19, indicated an active order for R2 to be up in her wheelchair for meals only, otherwise to be in bed, positioned on her side to relief pressure from her tailbone. R2's care plan, dated 12/23/22, indicated R2 had limited physical mobility with an intervention to be up in her wheelchair for meals only and transferred to bed 30 minutes after each meal. R2's entire electronic medical record (EMR) lacked documentation or evidence of R2 refusing cares, repositioning, or laying down in bed between meals. During continuous observation on 5/31/23 from 8:13 a.m. to 1:00 p.m., R2 was out of bed, sitting in her wheelchair without staff offering to transfer R2 to bed or reposition her. During observation on 5/31/23 at 8:13 a.m., R2 was in her wheelchair in the dining room eating breakfast. During observation on 5/31/23 at 8:47 a.m., R2 was in her wheelchair in the dining room, done with breakfast and sitting alone. During observation on 5/31/23 at 8:50 a.m., R2 was brought back to her room via her wheelchair and left sitting up in her room in her wheelchair.	F 686	1. In continuing compliance with F (686), Treatment Services to Prevent/Heal Pressure Ulcer. Woodlyn Heights Senior Living corrected the deficiency by assessing R2 and found wound to be stable with no negative outcome identified on 06/01/23. R2 care plan updated to encourage turning and repositioning every 2 hours by DON on 07/06/2023. All like residents' skin and wound care plans were reviewed by DON on 07/06/2023 to ensure each resident had appropriate interventions in place for prevention and healing of pressure injuries. Turning and repositing schedules were added to CNA Tasks in POC to ensure proper documentation and/or refusals by DON on 07/06/23. 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 pressure injury prevention measures including turning and repositioning per resident care plan by DON. 3. The DON and/or designee will audit turning and repositioning on random shifts of 5 residents 3x/week for 4 weeks, then 2x/week for 8 weeks, and then randomly to ensure continued compliance. The DON and/or designee will audit care plans for appropriate interventions for prevention and healing of pressure injuries of 3 residents per week for 4 weeks, 2 residents per week for 8 weeks, and then randomly to ensure continued	

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F 686	Continued From page 10 During observation on 5/31/23 at 9:11 a.m., facility staff entered R2's room to set up her intravenous medications but did not offer to transfer R2 into bed or help her shift positions in her wheelchair. During observation on 5/31/23 at 9:53 a.m., R2 was in her room, sitting in her wheelchair. During observation on 5/31/23 at 10:40 a.m., R2 was in her room, sitting in her wheelchair. During observation on 5/31/23 at 11:42 a.m., R2 was in her room, sitting in her wheelchair. A nursing assistant (NA) entered to take R2 out to lunch via her wheelchair. During observation on 5/31/23 at 12:53 p.m., R2 was finished with lunch, sitting in her wheelchair out in the dining room. During observation and interview on 5/31/23 at 1:00 p.m., R2 was laid down in bed via a Hoyer lift. R2 stated her tailbone area was sore and that the longer she sat up in her wheelchair, the more it hurt. R2 further stated facility staff did not offer to transfer her to bed between breakfast and lunch. During an interview on 6/1/23 at 7:16 a.m., NA-C stated R2 needed assistance from staff with all activities of daily living (ADLs). NA-C stated the nursing assistants get R2 up in her chair before breakfast and lay her back down in bed after lunch. NA-C stated facility staff do not offer to lay R2 down between breakfast and lunch and R2 does not often refuse cares from facility staff. During an interview on 6/1/23 at 7:23 a.m.,	F 686	compliance.	

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F 686	Continued From page 11 registered nurse (RN)-B stated she was not familiar with R2's cares. RN-B checked R2's care sheet which RN-B confirmed lacked any information on how often to reposition R2. RN-B further reviewed R2's medication administration record (MAR) which indicated R2 was to be up in her wheelchair for meals only. During an interview on 5/31/23 at 1:53 p.m., occupational therapist (OT)-A stated R2 does have a physician order to only be in her wheelchair for meals due to the pressure injury on her sacrum. OT-A further stated the importance of this because R2's wheelchair is not appropriate for her as it does not give her the support she needs. During an interview on 6/1/23 at 7:48 a.m., the director of nursing (DON) stated that R2 often refuses cares or to be repositioned. The DON confirmed there were no interventions in place to address R2's potential refusals for repositioning and that the EMR lacked documentation of refusals. The DON further stated the EMR lacked comprehensive assessments of what R2 would or would not agree to to promote healing of her facility acquired pressure injury or to prevent new pressure injuries form developing. The DON stated they do not have a proactive plan to manage R2's pressure injuries stating, "I don't know what else we can do". A policy on pressure injuries was requested and not received.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		7/6/23

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F 688	Continued From page 12 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide range of motion to one of one resident (R2) reviewed for range of motion who had limited range of motion in their upper extremities. Findings include: R2's quarterly Minimum Data Set (MDS), dated 3/3/23, indicated R2 was cognitively intact and needed extensive assistance with bed mobility, dressing, toileting, and personal hygiene and was totally dependent on staff for transfers via a Hoyer lift (an assistive device that allows residents who cannot transfer on their own be transferred between a bed and a chair using electrical or hydraulic power). R2's Medical Diagnosis list indicated R2 had a diagnosis of multiple sclerosis (a potentially	F 688	F (F688) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that	

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F 688	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 upper extremity range of motion program and	F 688	corrective action was necessary. 1. In continuing compliance with F(688), Increase /Prevent Decrease in ROM/Mobility. Woodlyn Heights Senior Living corrected 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, then 2x/week for 8 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.	

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F 688	Continued From page 14 further confirmed staff had not been completing ROM with R2. During an interview on 6/1/23 at 7:16 a.m., nursing assistant (NA)-C stated he was unaware of a ROM program for R2 and stated, "she can do it herself." NA-C further stated R2 does not often refuse cares. During an interview on 6/1/23 at 9:33 a.m., the director of nursing (DON) stated she was not aware of a ROM program for R2 and if she was refusing it. The DON further stated if it was on the care plan, the expectation was for it to be completed. A policy on ROM programs was requested but not received.	F 688		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F 732		7/6/23

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F 732	Continued From page 15 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure daily nurse staffing information was posted in a timely manner at the start of the shift and in a place visible to residents and visitors. This had the potential to affect all 63 residents, staff, and visitors who wanted to review this information. Findings include: During entrance to the nursing home on Monday, 5/30/23 at 11:00 a.m., the administrator in training was unable to locate the daily nurse staffing information. During observation on 5/31/23 at 8:19 a.m., the daily nurse staffing information was located on the wall outside of the first-floor nurse's station.	F 732	F 732 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility	

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F 732	Continued From page 16 The wall faced the nurse's station and was not visible to residents or visitors. The daily nurse staffing information was dated 5/30/23. During an observation 5/31/23 at 10:14 a.m., the daily nurse staffing information was still dated 5/30/23 and not visible to residents or visitors. During observation on 6/1/23 at 9:22 a.m., the daily nurse staffing information was dated 5/31/23 and not visible to residents or visitors. During an interview on 6/1/23 at 9:25 a.m., the administrator stated the staffing coordinator was responsible for hanging the daily nurse staffing information at the start of the shift each morning. During an interview on 6/1/23 at 9:50 a.m., the staffing coordinator stated she updated the daily nurse staffing information daily based on the schedule for the day and hung the posting by 6:30 a.m. or 7:00 a.m. each morning, including the weekends. The staffing coordinator confirmed the current daily nurse staffing information was dated 5/31/23. A policy on staff posting was requested but not received.	F 732	maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 732, Posted Nurse Staffing Information. Woodlyn Heights Senior Living corrected the deficiency by mounting a sign holder at the front desk, easily accessible to the staffing coordinator and at a location more readily visible. 2. To correct the deficiency and to ensure the problem does not recur staff were educated on 7/06/2023 on the staff posting process and location by the Executive Director. The Executive Director and/or designee will audit the postings daily for 2 weeks, weekly for 4 weeks, and then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		7/6/23

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F 757	Continued From page 17 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) narcotic medication to help facilitate person-centered care planning and reduce the risk of complication (i.e., constipation, sedation) for 2 of 5 residents (R46, R267) reviewed for unnecessary medication use. Findings include: R46's quarterly Minimum Data Set (MDS), dated 2/14/23, identified R46 had intact cognition, demonstrated no delusional thinking or beliefs, and required extensive assistance with several activities of daily living (ADLs). In addition, the MDS outlined R46 received both scheduled and PRN pain medications during the review; however, did not receive any non-medication intervention for pain. Further, R46 indicated they had frequent pain which they rated at eight (8) out	F 757	F (F757) PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	

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F 757	Continued From page 18 of 10 (10 being the worst possible). R46's care plan, dated 3/11/23, identified R46 had actual pain with needing medication management and listed a goal, "Will not have an interruption in normal activities due to pain ..." The care plan listed interventions to help R46 meet this goal which included, "Offer non-pharmacological interventions for pain relief such as music, repositioning, massage[,] etc." R46's Order Summary Report, dated 5/1/23, identified R46's current physician-ordered medications and treatments. This included active orders for acetaminophen (a mild pain reliever) 1000 milligrams (mg) twice a day scheduled and, in addition, twice a day PRN for pain; and Norco (a narcotic pain medication) 5-325 mg up to three times a day PRN for "severe pain." R46's corresponding Medication Administration Records (MAR), dated 4/2023 and 5/2023, identified R46's ordered medications with corresponding initials to demonstrate administration. This identified R46 had a total of 12 doses of the PRN Norco administered over the previous two month period including the following: On 4/2/23 at 10:22 a.m., with R46 rating their pain at 7/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/2/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 4/3/23 at 12:44 a.m., with R46 rating their pain at 6/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/3/23, identified the medication was given with	F 757	1. In continuing compliance with F(757), Drug Regimen is Free from Unnecessary Drugs. Woodlyn Heights Senior Living corrected the deficiency by reviewing R46, R267, and all like residents with orders for PRN narcotic medications to ensure non-pharmacological interventions are in place on 07/06/23. 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 attempting and documenting all non-pharmacological interventions prior to the administration of PRN narcotics. 3. The DON and/or designee will audit MARs/TARs for attempt of non-pharmacological interventions of all residents receiving PRN narcotics 3x/week for 4 weeks, then 2x/week for 8 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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 06/01/2023

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F 757	Continued From page 19 no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 4/4/23 at 5:30 a.m., with R46 rating their pain at 5/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/4/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 4/5/23 at 10:08 a.m., with R46 rating their pain at 6/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/5/23, identified the medication was given with no indication or symptoms recorded. In addition, another dose was provided on 4/5/23 at 7:59 p.m., with R46 rating their pain at 7/10, and the results being listed as, "Effective." However, again, neither of the notes identified what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 4/6/23 at 5:32 a.m., with R46 rating their pain at 4/10, and the results being listed as, "Ineffective." A corresponding progress note, dated 4/6/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 4/7/23 at 3:30 a.m., with R46 rating their pain at 6/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/7/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration.	F 757		

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F 757	Continued From page 20 On 4/25/23 at 12:54 p.m., with R46 rating their pain at 5/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/25/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 5/4/23 at 3:18 p.m., with R46 rating their pain at 6/10, and the results being listed as, "Effective." A corresponding progress note, dated 5/4/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. R46's medical record was reviewed and lacked evidence of what, if any, non-pharmacological interventions were offered or attempted prior to the administration of the PRN narcotic medication for nearly all of the administered doses from 4/1/23 to 5/30/23. On 5/31/23 at 8:02 a.m., R46 was observed laying in bed while in their room. R46 appeared comfortable and without obvious physical symptoms of pain (i.e., grimacing, yelling). R46 was interviewed and explained they consumed many medications as each physician visit seemed to have another "add on" for them to take. R46 stated they do, at times, have mild to severe pain due to arthritis and a history of migraines; and explained they consumed Norco when acetaminophen just wasn't enough to control it. R46 stated they could only recall "one time" in recent months when staff had offered any non-pharmacological interventions to them prior to giving Norco; however, added they were	F 757		

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F 757	Continued From page 21 unsure what, if any, non-pharmacological interventions may help the pain. When interviewed on 5/31/23 at 8:20 a.m., nursing assistant (NA)-A explained R46 needed an "extensive amount of help" with most cares and, at times, would complain of pain in their knees from arthritis. NA-A added, "That's about it," and explained they had never heard R46 complain about headaches or migraines. NA-A stated if R46 complained of pain, their response would be to notify the nurse and allow them to 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	F 757		

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F 757	Continued From page 22 they had reviewed R46's medical record. RN-B explained R46's care plan had non-pharmacological interventions listed which staff should be attempting and documenting with 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 adding, "They're supposed to do their notes." RN-B stated it was important to offer and attempt non-pharmacological approaches to help "reduce the administration of medication," and they added narcotics could cause potential addiction. R267's admission Minimum Data Set (MDS), dated 5/14/23, indicated R267 was cognitively intact and needed extensive assistance with several ADLs. R267's Physician Orders, dated 5/8/23, indicated R267 had an order for Oxycodone (a narcotic pain medication) five (5) milligrams (mg) every four (4) hours PRN (as needed) for severe pain. R267's care plan, dated 5/8/23, indicated R267 had "actual/potential" for pain with need for medication management, with an intervention to "offer non-pharmacological interventions for pain relief such as music, repositioning, massage etc". R267's treatment record, dated 5/8/23, indicated for the nurses to observe pain every shift and document any verbal and/or non-verbal indicators of pain and interventions, including nonpharmacological interventions in a pain	F 757		

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F 757	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. On 5/17/12 at 8:27 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 3 on a scale of one (1)-10. On 5/18/23 at 5:29 a.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. On 5/19/23 at 11:27 p.m., with a documented pain rating of 6 on a scale of one (1)-10. On 5/24/23 at 12:55 a.m., with a documented pain rating of 6 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. R267's entire electronic medical record (EMR), including progress notes, lacked any indication of	F 757		

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F 757	Continued From page 24 what, if any, non-pharmacological interventions were offered or attempted prior to Oxycodone administration. The EMR further lacked assessments of R267's pain to include symptoms or location of pain. During an interview on 6/1/23 at 8:08 a.m., registered nurse (RN)-A stated if a resident asked for a PRN pain medication the nurses were expected to do a pain assessment of what hurts, what was going on to cause the pain and the resident's pain level and document it in a progress note. RN-A stated the nurses should be offering non-pharmacological interventions for pain and documenting the interventions in a progress note so staff were aware of what works or does not work for each resident. RN-A reviewed R267's progress notes and confirmed there were no documented pain assessments or attempts at non-pharmacological pain interventions. During an interview on 6/1/23 at 9:33 a.m., the director of nursing (DON) stated the expectation was for nurses to offer non-pharmacological interventions for pain. The DON confirmed non-pharmacological pain interventions were care planned but nurses were not documenting if any non-pharmacological pain interventions were being offered or tried. When interviewed on 5/31/23 at 1:04 p.m., the consulting pharmacist (CP) stated the expectation was for staff to attempt and document all non-pharmacological interventions with PRN narcotic administration. CP added, "It's a documentation issue."	F 757		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		7/7/23

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F 804	Continued From page 25 CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food was served at warm, palatable temperatures for 3 of 3 residents (R19, R46, and R267) who were observed to be served and/or complained about inappropriate food temperature. Findings include: R19 R19's quarterly Minimum Data Set (MDS) dated 3/13/23, indicated R19 had intact cognition. During interview on 5/31/23 at 8:49 a.m., R19 stated she declined her breakfast "because the food is cold". During interview with dietary manager (DM)-A on 5/31/23 at 9:18 a.m., DM-A stated R19's concern about cold food is voiced by many residents. DM-A stated the food "It's not always cold" and stated the food would be hotter for residents if they all ate in the dining room instead of their rooms. "I tell my residents, if they came out to the dining room the food would be hotter". DM-A stated "we don't always have enough staff" to	F 804	F 804 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 804, Nutritive Value/Appear, Palatable/Prefer Temp. Woodlyn Heights Senior Living corrected the deficiency by	

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F 804	Continued From page 26 serve the food. R46 R46's quarterly MDS dated 5/11/23, indicted R46 had intact cognition. During interview on 5/30/23 at 7:29 a.m., R46 stated, "food sucks", and warm food is "cold for sure" most of the time it is served. R46 stated she has refused "hot plate stuff" because it is "always cold". R46 stated the facility staff were aware of the concerns and no solutions were offered. During an observation and interview on 5/30/23 at 8:18 a.m., dietary aide (DA)-B entered R46's room with a breakfast tray that included a bowl of cereal, carton of milk, two sausage links, two pieces of toast and one hard-boiled egg. R46 asked surveyor to touch the sausage links to show how warm they were. DA-B acknowledged they were cool to the touch. DA-B stated the food trays should be served by both the nursing assistants and dietary aides, however the "aides should be helping us but don't". During interview with nursing assistant (NA)-A on 5/31/23 at 8:20 a.m., NA-A stated she had was aware of the same complaints of cold food from "a lot of the residents". NA-A stated the food is "plated downstairs and is cold when arrives up here finally". NA-A stated facility management is aware and their response is to encourage all of the residents to eat in the dining room instead of their rooms. NA-A stated nursing assistants " are having to help pass trays often as kitchen will say short staffed". R267 R267's Admissions MDS dated 5/14/23, indicated	F 804	acquiring two CAMBRO Meal Delivery Carts on 06/06/2023. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 07/07/2023 on proper usage of new CAMBRO meal delivery carts by the Dietary Manager. The Dietary Manger and/or designee will audit room tray food temperatures 3 times per week for 4 weeks and weekly for 8 weeks and then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the Dietary Manager and/or designee will report identified concerns through the community's QA Process.	

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F 804	Continued From page 27 R267 had intact cognition. During interview with R267 on 5/30/23 at 7:47 a.m., R267 stated "most of the time the food is cold". During interview with R267 on 5/31/23 at 9:24 a.m., R267 stated, "I just ate cold cereal for breakfast today because the hot food is always cold by the time it gets to me". During interview with DA-A on 5/31/23 at 8:10 a.m., DA-A stated "residents do tell me that their food is cold. It is hard when I am the only one passing the trays. No one wants to help". During interview with cook (C)-A on 5/31/23 at 8:23 a.m., C-A stated there was not enough staff to pass trays. "the food is ice cold by the time it gets to the residents because we don't have the help to pass the trays". During interview with licensed practical nurse (LPN)-A on 5/31/23 at 9:42 a.m., LPN-A stated, "I know the food is not as hot as it should be when they (residents) get it. Hard to make time to pass trays when we are passing meds and answering lights." During interview with DM-A on 5/31/23 at 10:23 a.m., DM-A stated there were enough staff to meet the needs of the residents but that the residents do not want to come out of their rooms to eat meals in the dining room. This reluctance to eat in the dining room is the reason why the resident meal trays are cold. "I know we can't force them to come out" of their rooms. DM-A stated the responsibility to pass meal trays is the dietary staff and the nursing assistants and that	F 804		

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F 804	Continued From page 28 the administrator is aware of the issue with cold food complaints. During interview with the administrator on 6/1/23 at 6:18 a.m., the administrator stated the food temperature complaints is an "on-going issue". The administrator stated the facility implemented a plan to arrange facility activities immediately before meal service but that has not met with much success. The administrator stated the dietary aides and nursing assistants are responsible for passing meal trays and the "nursing assistants do not help as much as they should". The administrator stated, "yes, the residents are getting cold food when the trays are being passed out".	F 804		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a safe, functional, and sanitary living environment for 3 of 6 residents (R46, R52, R54), reviewed for environmental concerns. Findings include: During observation and interview on 5/30/23 at 7:33 a.m., R46 had a brown-colored radiator along the bottom of the wall on the right side next to the bed. The radiator was pulled several inches away from the wall and was loose. R46 stated the	F 921	F 921 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for	7/6/23

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F 921	Continued From page 29 radiator had been that way for about a month and was told "someday" it would be fixed. During observation on 5/30/23 at a.m., R52 was laying in bed receiving nutrition through a feeding tube. The bottom of the pole was visibly soiled with a copious amount of light-brown splattering from the feeding which was dry to appearance and touch . During observation and interview on 5/30/23 at 10:47 a.m., R54 was sitting in a chair in her room receiving oxygen from a NewLife Elite AirSep concentrator. The filter on the backside of the concentrator was covered with copious grey-colored dust and was nearly occluded. R54 stated "I don't know what they do" in regards to when or how often staff change or clean the filter. During an obsevation and interview on 06/01/23 at 11:01 a.m., registered nurse (RN)-C verified the filter on the back of the oxygen concentrator (in R54's room) was dirty and stated the night nurse was responsible for changing the tubing and filter. He further verified the bottom of the tube feeding pole (in R52's room) had dried and crusted food splattering all over it and the night nurse was also responsible for cleaning it. RN-C also stated anyone can clean it, and if a nurse notices it, they should clean it. During an interview on 6/1/23 at 11:08 a.m., nursing assistant (NA)-D stated staff are supposed to put in a TELS (software program for maintenance requests) request when things need to be repaired. NA-D stated you can access the TELS system on the dashboard when logging onto the computer.	F 921	procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 921, Safe/Functional/Sanitary/Comfortable Environment. Woodlyn Heights Senior Living corrected the deficiency by fixing R46 brown-colored radiator on 5/30/2023. On 5/30/23, Maintenance started to complete a work order system for residents that discharge to ensure rooms are fixed. On 06/01/2023, the DON and Nurse cleaned R52 and all like resident tube feeding poles. On 06/01/2023, DON and nurse changed R54 and all like resident filters for the oxygen concentrator. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 07/06/23 on completing orders for cleaning tube feeding poles and cleaning air filters for the oxygen concentrators by DON. The DON and/or designee will audit cleaning of tube feeding poles 3x/week for 4 weeks, weekly for 8 weeks, and then randomly to ensure continued compliance. The DON and/or designee will audit weekly cleaning of air filters for the oxygen concentrators weekly for 12 weeks and then randomly to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 06/01/2023

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

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F 921	Continued From page 30 During an observation and interview on 6/1/23 at 11:48 a.m., the director of maintenance verified the radiator (in R46's room), was coming off the wall and loose. He further stated he had fixed R46's bed about a week ago, noticed the radiator was in need of repair but forgot to come back and fix it. The director of maintenance stated staff are supposed to put in a TELS request when something needs to be repaired but they will often just tell him about it instead of putting it in the TELS system and he may forget about it stating "I can't remember everything." During an interview on 6/1/23 at 12:43 p.m. the director of nursing (DON) stated she would expect the nurse who was hanging the formula for the tube feeding to be checking the pole and making sure it was clean. She further stated any nurse that noticed it was dirty, should clean it. The DON stated she would also expect the nurses to change the filters in the residents oxygen concentrators when they change the tubing. The operation manual for the NewLife Elite AirSep oxygen concentrator (undated) indicated the external air intake gross particle filter was located on the back of the unit and should be cleaned once a week. The facility's policy regarding cleaning equipment was requested but not received.	F 921	3. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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	245320	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/01/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 01 ,2023. At the time of this survey, Woodlyn Heights Healthcare Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Woodlyn Heights Healthcare Center is a 2-story building with no basement. The building was built in 1973 and was determined to be of Type II(111) construction. In 2014 a single-story addition was added to the East and was determined to be of Type II(111) construction. The building is fully fire sprinkler protected and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification	K 000		

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	245320	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/01/2023**

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K 000	Continued From page 2 The facility has a capacity of 79 beds and had a census of 65 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain Sprinkler System per NFPA 101 (2012 edition), Life Safety Code section 9.7.5, and NFPA 25 2011 section 5.3.1.1.1. This deficient finding could have a widespread impact on the residents within the facility.	K 353	K 353 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in	6/30/23

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K 353	Continued From page 3 Findings include: On 06/01/2023 at 10:00 AM, it was revealed by observation that the facility has fire sprinklers have been in service for 50 years, they shall be replaced or representative samples from one or more sample areas shall be tested. An interview with the Facility Maintenance director verified this or these deficient findings at the time of discovery.	K 353	the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with K 353, Sprinkler System – Maintenance and Testing. Woodlyn Heights Senior Living Facility corrected the deficiency by collaborating with qualified vendor, Summit. This plan will ensure that all sprinklers will not go beyond their 50 year life and will be replaced prior. 2. To correct the deficiency and to ensure the problem does not recur staff were educated on 7/6 and 7/7 on Life Safety by Jeffery Treitline. The Maintenance Director and/or designee will audit the replacement sprinklers and include documentation in TELS (Woodlyn Heights Preventative Maintenance Documentation) and the Life Safety Manual. 3. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the Maintenance Director and/or designee will report identified concerns through the community's QA Process.	

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K 712	Continued From page 4	K 712		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct Fire drills per NFPA 101 (2012 edition), Life Safety Code, section(s)19.7.1.4 through 19.7.1.7. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/01/2023 at 0930 PM, it was revealed by a review of available documentation that the facility is missing fire drills for the 1st quarter of 2023, all shafts, 2nd quarter, 2nd shaft, 3rd quarter, all shifts, and 4th quarter, all shifts. The facility is under new management as of April 2023. An interview with Facility Director verified this deficient finding at the time of discovery.	K 712	K 712 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	6/30/23

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K 712	Continued From page 5	K 712	1. In continuing compliance with K 712, Fire Drills. The Woodlyn Heights Senior Living Facility corrected the deficiency by conducting monthly drills as required by the state. 2. To correct the deficiency and to ensure the problem does not recur staff were educated on 7/6 on fire drills by Jeffery Treitline. The Maintenance Director and/or designee will audit the Life Safety requirements during the monthly safety meeting and include documentation in TELS (Woodlyn Heights Preventative Maintenance Documentation) and the Life Safety Manual. 3. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the Maintenance Director and/or designee will report identified concerns through the community's QA Process.	

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	00829	A. BUILDING: _____ B. WING _____	C 06/01/2023

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WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/30/23 to 6/1/23, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed. Woodlyn Heights Healthcare Center was found not in compliance with the MN State Licensure, and the following	2 000		

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2 000	Continued From page 1 correction orders were issued. The following complaints were reviewed during the survey: H53202430C (MN92769) H53202431C (MN86824); with licensing orders issued at 0960, 1665, and 0915 H53202432C (MN87567) H53202433C (MN87589); with licensing order issued at 1665 H53202434C (MN89667) H53202435C (MN89490) Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. MDH is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf	2 000		

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2 000	Continued From page 2 obul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	2 890		7/6/23

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2 890	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide range of motion to one of one resident (R2) reviewed for range of motion who had limited range of motion in their upper extremities. Findings include: R2's quarterly Minimum Data Set (MDS), dated 3/3/23, indicated R2 was cognitively intact and needed extensive assistance with bed mobility, dressing, toileting, and personal hygiene and was totally dependent on staff for transfers via a Hoyer lift (an assistive device that allows residents who cannot transfer on their own be transferred between a bed and a chair using electrical or hydraulic power). R2's Medical Diagnosis list indicated R2 had a diagnosis of multiple sclerosis (a potentially 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	2 890	corrected	

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2 890	Continued From page 4 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 upper extremity range of motion program and further confirmed staff had not been completing ROM with R2. During an interview on 6/1/23 at 7:16 a.m., nursing assistant (NA)-C stated he was unaware of a ROM program for R2 and stated, "she can do it herself." NA-C further stated R2 does not often refuse cares. During an interview on 6/1/23 at 9:33 a.m., the director of nursing (DON) stated she was not aware of a ROM program for R2 and if she was refusing it. The DON further stated if it was on the care plan, the expectation was for it to be completed. A policy on ROM programs was requested but not received.	2 890		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on ensuring range-of-motion (ROM) programs are attempted and completed timely; then educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 890		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident admitted without a pressure injury did not develop a pressure injury while in the facility and failed to	2 900	corrected	7/6/23

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2 900	Continued From page 6 implement proper interventions for prevention and healing of pressure injuries for one of one resident (R2) reviewed for pressure injuries. Findings include: R2's quarterly Minimum Data Set (MDS), dated 3/3/23, indicated R2 was cognitively intact and needed extensive assistance with bed mobility, dressing, toileting, and personal hygiene and was totally dependent on staff for transfers via a Hoyer lift (an assistive device that allows residents who cannot transfer on their own be transferred between a bed and a chair using electrical or hydraulic power). The MDS further indicated R2 had a stage IV, facility acquired pressure injury on her sacrum (an open wound on the tailbone with full thickness tissue loss with exposed bone, tendon, or muscle). R2's Medical Diagnosis list indicated R2 had a diagnosis of multiple sclerosis (a potentially disabling disease of the brain and spinal cord). R2's Physician orders, dated 3/19/19, indicated an active order for R2 to be up in her wheelchair for meals only, otherwise to be in bed, positioned on her side to relief pressure from her tailbone. R2's care plan, dated 12/23/22, indicated R2 had limited physical mobility with an intervention to be up in her wheelchair for meals only and transferred to bed 30 minutes after each meal. R2's entire electronic medical record (EMR) lacked documentation or evidence of R2 refusing cares, repositioning, or laying down in bed between meals. During continuous observation on 5/31/23 from	2 900		

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2 900	Continued From page 7 8:13 a.m. to 1:00 p.m., R2 was out of bed, sitting in her wheelchair without staff offering to transfer R2 to bed or reposition her. During observation on 5/31/23 at 8:13 a.m., R2 was in her wheelchair in the dining room eating breakfast. During observation on 5/31/23 at 8:47 a.m., R2 was in her wheelchair in the dining room, done with breakfast and sitting alone. During observation on 5/31/23 at 8:50 a.m., R2 was brought back to her room via her wheelchair and left sitting up in her room in her wheelchair. During observation on 5/31/23 at 9:11 a.m., facility staff entered R2's room to set up her intravenous medications but did not offer to transfer R2 into bed or help her shift positions in her wheelchair. During observation on 5/31/23 at 9:53 a.m., R2 was in her room, sitting in her wheelchair. During observation on 5/31/23 at 10:40 a.m., R2 was in her room, sitting in her wheelchair. During observation on 5/31/23 at 11:42 a.m., R2 was in her room, sitting in her wheelchair. A nursing assistant (NA) entered to take R2 out to lunch via her wheelchair. During observation on 5/31/23 at 12:53 p.m., R2 was finished with lunch, sitting in her wheelchair out in the dining room. During observation and interview on 5/31/23 at 1:00 p.m., R2 was laid down in bed via a Hoyer lift. R2 stated her tailbone area was sore and that	2 900		

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2 900	Continued From page 8 the longer she sat up in her wheelchair, the more it hurt. R2 further stated facility staff did not offer to transfer her to bed between breakfast and lunch. During an interview on 6/1/23 at 7:16 a.m., NA-C stated R2 needed assistance from staff with all activities of daily living (ADLs). NA-C stated the nursing assistants get R2 up in her chair before breakfast and lay her back down in bed after lunch. NA-C stated facility staff do not offer to lay R2 down between breakfast and lunch and R2 does not often refuse cares from facility staff. During an interview on 6/1/23 at 7:23 a.m., registered nurse (RN)-B stated she was not familiar with R2's cares. RN-B checked R2's care sheet which RN-B confirmed lacked any information on how often to reposition R2. RN-B further reviewed R2's medication administration record (MAR) which indicated R2 was to be up in her wheelchair for meals only. During an interview on 5/31/23 at 1:53 p.m., occupational therapist (OT)-A stated R2 does have a physician order to only be in her wheelchair for meals due to the pressure injury on her sacrum. OT-A further stated the importance of this because R2's wheelchair is not appropriate for her as it does not give her the support she needs. During an interview on 6/1/23 at 7:48 a.m., the director of nursing (DON) stated that R2 often refuses cares or to be repositioned. The DON confirmed there were no interventions in place to address R2's potential refusals for repositioning and that the EMR lacked documentation of refusals. The DON further stated the EMR lacked comprehensive assessments of what R2 would or	2 900		

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2 900	Continued From page 9 would not agree to to promote healing of her facility acquired pressure injury or to prevent new pressure injuries form developing. The DON stated they do not have a proactive plan to manage R2's pressure injuries stating, "I don't know what else we can do". A policy on pressure injuries was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on ensuring accurate and comprehensive assessment of pressure ulcer needs, including refusals of care, are completed and implemented; then educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet;	2 915		7/6/23

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2 915	Continued From page 10 (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine baths and personal hygiene for one of one residents (R267) reviewed for activities of daily living (ADLs). Findings include: R267's admission Minimum Data Set (MDS), dated 5/14/23, indicated R267 was cognitively intact and needed extensive assistance with transfers, bed mobility, locomotion on and off the unit, dressing and toilet use and limited assistance with personal hygiene. R267's Medical Diagnosis list indicated R267 had several medical diagnoses including severe chronic kidney disease and acquired absence of left leg below the knee. R267's care plan, dated 5/8/23, lacked any interventions to assist R267 with showering or bathing and indicated R267 needed assist of one staff member for dressing/undressing and assistance with toileting and occasional 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.	2 915	corrected	

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2 915	Continued From page 11 During an interview and observation on 5/30/23 at 7:35 a.m., R267 stated she had one bed bath since she was admitted to the facility and stated, "they just kind of skip over me when it's time for a bath". R267 was wearing a grey, button-down pajama shirt and light pink shorts. R267's hair appeared disheveled and matted down in the back. During observation on 5/30/23 at 11:09 a.m., R267 was wearing the same grey, button-down pajama shirt and light pink shorts as that morning. During observation and interview on 5/31/23 at 9:18 a.m., R267 was wearing the same grey, button-down pajama shirt and light pink shorts as 5/30/23. R267 stated nobody had helped her with any personal hygiene that morning and further stated, "I couldn't even wash my face because they did not bring me washcloths or towels". During interview and observation on 5/31/23 at 2:03 p.m., R267 was out in the facility hallway, crying, stating she had been in the same clothes since Friday and still had not received any washcloths or towels to wash up with. During observation and interview on 6/1/23 at 8:30 a.m., R267 was wearing the same grey, button-down pajama shirt from 5/30/23. During an interview on 5/31/23 at 9:42 a.m., nursing assistant (NA)-B stated the NAs use the Kardex to know what cares to provide a resident. NA-B further stated there was a bath schedule at the nurse's station and confirmed R267's bath day was Sunday evenings. NA-B also confirmed that the NAs documented when a bath was given	2 915		

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2 915	Continued From page 12 under Tasks in the EMR. NA-B stated R267 does not refuse cares but could be particular on the timing of her cares. During an interview on 6/1/23 at 8:08 a.m., registered nurse (RN)-A stated it was expected that baths or showers were completed the day they were scheduled. RN- A stated she occasionally will get notified if a bath or shower is missed, but often has to ask if they were completed. During an interview on 6/1/23 at 9:33 a.m., the director of nursing (DON) stated the expectation was for showers and baths to be completed the day they were scheduled. A policy on ADLs was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on ensuring hygiene and grooming cares are provided timely; then educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 915		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food.	2 960		7/7/23

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2 960	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food was served at warm, palatable temperatures for 3 of 3 residents (R19, R46, and R267) who were observed to be served and/or complained about inappropriate food temperature. Findings include: R19 R19's quarterly Minimum Data Set (MDS) dated 3/13/23, indicated R19 had intact cognition. During interview on 5/31/23 at 8:49 a.m., R19 stated she declined her breakfast "because the food is cold". During interview with dietary manager (DM)-A on 5/31/23 at 9:18 a.m., DM-A stated R19's concern about cold food is voiced by many residents. DM-A stated the food "It's not always cold" and stated the food would be hotter for residents if they all ate in the dining room instead of their rooms. "I tell my residents, if they came out to the dining room the food would be hotter". DM-A stated "we don't always have enough staff" to serve the food. R46 R46's quarterly MDS dated 5/11/23, indicted R46 had intact cognition. During interview on 5/30/23 at 7:29 a.m., R46 stated, "food sucks", and warm food is "cold for sure" most of the time it is served. R46 stated she has refused "hot plate stuff" because it is "always cold". R46 stated the facility staff were aware of the concerns and no solutions were offered.	2 960	corrected	

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2 960	Continued From page 14 During an observation and interview on 5/30/23 at 8:18 a.m., dietary aide (DA)-B entered R46's room with a breakfast tray that included a bowl of cereal, carton of milk, two sausage links, two pieces of toast and one hard-boiled egg. R46 asked surveyor to touch the sausage links to show how warm they were. DA-B acknowledged they were cool to the touch. DA-B stated the food trays should be served by both the nursing assistants and dietary aides, however the "aides should be helping us but don't". During interview with nursing assistant (NA)-A on 5/31/23 at 8:20 a.m., NA-A stated she had was aware of the same complaints of cold food from "a lot of the residents". NA-A stated the food is "plated downstairs and is cold when arrives up here finally". NA-A stated facility management is aware and their response is to encourage all of the residents to eat in the dining room instead of their rooms. NA-A stated nursing assistants " are having to help pass trays often as kitchen will say short staffed". R267 R267's Admissions MDS dated 5/14/23, indicated R267 had intact cognition. During interview with R267 on 5/30/23 at 7:47 a.m., R267 stated "most of the time the food is cold". During interview with R267 on 5/31/23 at 9:24 a.m., R267 stated, "I just ate cold cereal for breakfast today because the hot food is always cold by the time it gets to me". During interview with DA-A on 5/31/23 at 8:10 a.m., DA-A stated "residents do tell me that their	2 960		

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2 960	Continued From page 15 food is cold. It is hard when I am the only one passing the trays. No one wants to help". During interview with cook (C)-A on 5/31/23 at 8:23 a.m., C-A stated there was not enough staff to pass trays. "the food is ice cold by the time it gets to the residents because we don't have the help to pass the trays". During interview with licensed practical nurse (LPN)-A on 5/31/23 at 9:42 a.m., LPN-A stated, "I know the food is not as hot as it should be when they (residents) get it. Hard to make time to pass trays when we are passing meds and answering lights." During interview with DM-A on 5/31/23 at 10:23 a.m., DM-A stated there were enough staff to meet the needs of the residents but that the residents do not want to come out of their rooms to eat meals in the dining room. This reluctance to eat in the dining room is the reason why the resident meal trays are cold. "I know we can't force them to come out" of their rooms. DM-A stated the responsibility to pass meal trays is the dietary staff and the nursing assistants and that the administrator is aware of the issue with cold food complaints. During interview with the administrator on 6/1/23 at 6:18 a.m., the administrator stated the food temperature complaints is an "on-going issue". The administrator stated the facility implemented a plan to arrange facility activities immediately before meal service but that has not met with much success. The administrator stated the dietary aides and nursing assistants are responsible for passing meal trays and the "nursing assistants do not help as much as they should". The administrator stated, "yes, the	2 960		

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2 960	Continued From page 16 residents are getting cold food when the trays are being passed out". SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review applicable practices and policies on timely delivery of meal trays to ensure palatable temperature is maintained; then educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 960		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services,	21535		7/6/23

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21535	Continued From page 17 Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) narcotic medication to help facilitate person-centered care planning and reduce the risk of complication (i.e., constipation, sedation) for 2 of 5 residents (R46, R267) reviewed for unnecessary medication use. Findings include: R46's quarterly Minimum Data Set (MDS), dated 2/14/23, identified R46 had intact cognition, demonstrated no delusional thinking or beliefs, and required extensive assistance with several activities of daily living (ADLs). In addition, the MDS outlined R46 received both scheduled and PRN pain medications during the review; however, did not receive any non-medication intervention for pain. Further, R46 indicated they had frequent pain which they rated at eight (8) out of 10 (10 being the worst possible). R46's care plan, dated 3/11/23, identified R46 had actual pain with needing medication management and listed a goal, "Will not have an interruption in normal activities due to pain ..." The care plan listed interventions to help R46 meet this goal which included, "Offer non-pharmacological interventions for pain relief	21535	corrected	

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21535	Continued From page 18 such as music, repositioning, massage[,] etc." R46's Order Summary Report, dated 5/1/23, identified R46's current physician-ordered medications and treatments. This included active orders for acetaminophen (a mild pain reliever) 1000 milligrams (mg) twice a day scheduled and, in addition, twice a day PRN for pain; and Norco (a narcotic pain medication) 5-325 mg up to three times a day PRN for "severe pain." R46's corresponding Medication Administration Records (MAR), dated 4/2023 and 5/2023, identified R46's ordered medications with corresponding initials to demonstrate administration. This identified R46 had a total of 12 doses of the PRN Norco administered over the previous two month period including the following: On 4/2/23 at 10:22 a.m., with R46 rating their pain at 7/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/2/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 4/3/23 at 12:44 a.m., with R46 rating their pain at 6/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/3/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 4/4/23 at 5:30 a.m., with R46 rating their pain at 5/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/4/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were	21535		

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	00829	A. BUILDING: _____ B. WING _____	C 06/01/2023

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21535	Continued From page 19 offered or attempted prior to administration. On 4/5/23 at 10:08 a.m., with R46 rating their pain at 6/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/5/23, identified the medication was given with no indication or symptoms recorded. In addition, another dose was provided on 4/5/23 at 7:59 p.m., with R46 rating their pain at 7/10, and the results being listed as, "Effective." However, again, neither of the notes identified what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 4/6/23 at 5:32 a.m., with R46 rating their pain at 4/10, and the results being listed as, "Ineffective." A corresponding progress note, dated 4/6/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 4/7/23 at 3:30 a.m., with R46 rating their pain at 6/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/7/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 4/25/23 at 12:54 p.m., with R46 rating their pain at 5/10, and the results being listed as, "Effective." A corresponding progress note, dated 4/25/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. On 5/4/23 at 3:18 p.m., with R46 rating their pain at 6/10, and the results being listed as,	21535		

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21535	Continued From page 20 "Effective." A corresponding progress note, dated 5/4/23, identified the medication was given with no indication or symptoms recorded; nor what, if any, non-pharmacological interventions were offered or attempted prior to administration. R46's medical record was reviewed and lacked evidence of what, if any, non-pharmacological interventions were offered or attempted prior to the administration of the PRN narcotic medication for nearly all of the administered doses from 4/1/23 to 5/30/23. On 5/31/23 at 8:02 a.m., R46 was observed laying in bed while in their room. R46 appeared comfortable and without obvious physical symptoms of pain (i.e., grimacing, yelling). R46 was interviewed and explained they consumed many medications as each physician visit seemed to have another "add on" for them to take. R46 stated they do, at times, have mild to severe pain due to arthritis and a history of migraines; and explained they consumed Norco when acetaminophen just wasn't enough to control it. R46 stated they could only recall "one time" in recent months when staff had offered any non-pharmacological interventions to them prior to giving Norco; however, added they were unsure what, if any, non-pharmacological interventions may help the pain. When interviewed on 5/31/23 at 8:20 a.m., nursing assistant (NA)-A explained R46 needed an "extensive amount of help" with most cares and, at times, would complain of pain in their knees from arthritis. NA-A added, "That's about it," and explained they had never heard R46 complain about headaches or migraines. NA-A stated if R46 complained of pain, their response would be to notify the nurse and allow them to	21535		

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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 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 staff should be attempting and documenting with 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 adding, "They're supposed to do their notes." RN-B stated it was important to offer and attempt	21535		

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21535	Continued From page 22 non-pharmacological approaches to help "reduce the administration of medication," and they added narcotics could cause potential addiction. R267's admission Minimum Data Set (MDS), dated 5/14/23, indicated R267 was cognitively intact and needed extensive assistance with several ADLs. R267's Physician Orders, dated 5/8/23, indicated R267 had an order for Oxycodone (a narcotic pain medication) five (5) milligrams (mg) every four (4) hours PRN (as needed) for severe pain. R267's care plan, dated 5/8/23, indicated R267 had "actual/potential" for pain with need for medication management, with an intervention to "offer non-pharmacological interventions for pain relief such as music, repositioning, massage etc". R267's treatment record, dated 5/8/23, indicated for the nurses to observe pain every shift and document any verbal and/or non-verbal indicators of pain and interventions, including nonpharmacological interventions in a pain 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	21535		

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21535	Continued From page 23 p.m., with a documented pain rating of 7 on a scale of one (1)-10. On 5/17/12 at 8:27 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 3 on a scale of one (1)-10. On 5/18/23 at 5:29 a.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. On 5/19/23 at 11:27 p.m., with a documented pain rating of 6 on a scale of one (1)-10. On 5/24/23 at 12:55 a.m., with a documented pain rating of 6 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. R267's entire electronic medical record (EMR), including progress notes, lacked any indication of what, if any, non-pharmacological interventions were offered or attempted prior to Oxycodone administration. The EMR further lacked assessments of R267's pain to include symptoms or location of pain. During an interview on 6/1/23 at 8:08 a.m., registered nurse (RN)-A stated if a resident asked for a PRN pain medication the nurses were expected to do a pain assessment of what hurts, what was going on to cause the pain and the resident's pain level and document it in a progress note. RN-A stated the nurses should be offering non-pharmacological interventions for pain and documenting the interventions in a progress note so staff were aware of what works	21535		

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21535	Continued From page 24 or does not work for each resident. RN-A reviewed R267's progress notes and confirmed there were no documented pain assessments or attempts at non-pharmacological pain interventions. During an interview on 6/1/23 at 9:33 a.m., the director of nursing (DON) stated the expectation was for nurses to offer non-pharmacological interventions for pain. The DON confirmed non-pharmacological pain interventions were care planned but nurses were not documenting if any non-pharmacological pain interventions were being offered or tried. When interviewed on 5/31/23 at 1:04 p.m., the consulting pharmacist (CP) stated the expectation was for staff to attempt and document all non-pharmacological interventions with PRN narcotic administration. CP added, "It's a documentation issue." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on ensuring non-pharmacological interventions are attempted and recorded prior to the administration of as-needed (PRN) narcotic medications; then educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21535		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean,	21665		7/6/23

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21665	Continued From page 25 functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a safe, functional, and sanitary living environment for 3 of 6 residents (R46, R52, R54), reviewed for environmental concerns. Findings include: During observation and interview on 5/30/23 at 7:33 a.m., R46 had a brown-colored radiator along the bottom of the wall on the right side next to the bed. The radiator was pulled several inches away from the wall and was loose. R46 stated the radiator had been that way for about a month and was told "someday" it would be fixed. During observation on 5/30/23 at a.m., R52 was laying in bed receiving nutrition through a feeding tube. The bottom of the pole was visibly soiled with a copious amount of light-brown splattering from the feeding which was dry to appearance and touch . During observation and interview on 5/30/23 at 10:47 a.m., R54 was sitting in a chair in her room receiving oxygen from a NewLife Elite AirSep concentrator. The filter on the backside of the concentrator was covered with copious grey-colored dust and was nearly occluded. R54 stated "I don't know what they do" in regards to when or how often staff change or clean the filter. During an obsevation and interview on 06/01/23	21665	corrected	

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21665	Continued From page 26 at 11:01 a.m., registered nurse (RN)-C verified the filter on the back of the oxygen concentrator (in R54's room) was dirty and stated the night nurse was responsible for changing the tubing and filter. He further verified the bottom of the tube feeding pole (in R52's room) had dried and crusted food splattering all over it and the night nurse was also responsible for cleaning it. RN-C also stated anyone can clean it, and if a nurse notices it, they should clean it. During an interview on 6/1/23 at 11:08 a.m., nursing assistant (NA)-D stated staff are supposed to put in a TELS (software program for maintenance requests) request when things need to be repaired. NA-D stated you can access the TELS system on the dashboard when logging onto the computer. During an observation and interview on 6/1/23 at 11:48 a.m., the director of maintenance verified the radiator (in R46's room), was coming off the wall and loose. He further stated he had fixed the R46's bed about a week ago, noticed the radiator was in need of repair but forgot to come back and fix it. The director of maintenance stated staff are supposed to put in a TELS request when something needs to be repaired but they will often just tell him about it instead of putting it in the TELS system and he may forget about it stating "I can't remember everything." During an interview on 6/1/23 at 12:43 p.m. the director of nursing (DON) stated she would expect the nurse who was hanging the formula for the tube feeding to be checking the pole and making sure it was clean. She further stated any nurse that noticed it was dirty, should clean it. The DON stated she would also expect the nurses to chang the filters in the residents oxygen	21665		

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21665	Continued From page 27 concentrators when they change the tubing. The operation manual for the NewLife Elite AirSep oxygen concentrator (undated) indicated the external air intake gross particle filter was located on the back of the unit and should be cleaned once a week. The facility's policy regarding cleaning equipment was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review applicable policies and practices for ensuring resident care equipment and room(s) are kept in a clean, sanitary manner; then educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21665		

DEPARTMENT OF HEALTH

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

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

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: OI2O12

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

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us