| | N SERVICES ARE/MEDICAID CERTIFI TO BE COMPLETED BY 1 | | AND TRANSMITTAL | DICARE & MEDICAID SERVICES ID: QPXY |
|---|--|--|---|--|
| 1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245235 2.STATE VENDOR OR MEDICAID NO. (L2) 662675000 | 3. NAME AND ADDRESS OF FA (L3) WOODBURY HEALTH ((L4) 7012 LAKE ROAD (L5) WOODBURY, MN | CILITY | | Facility ID: 00803 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint |
| 5. EFFECTIVE DATE CHANGE OF OWNERSHIP | 7. PROVIDER/SUPPLIER CATE | | <u>02</u> (L7) | 7. On-Site Visit 9. Other 8. Full Survey After Complaint |
| (L9) 05/01/2007 6. DATE OF SURVEY 05/24/2018 (L34) 8. ACCREDITATION STATUS: | 01 Hospital05 HHA02 SNF/NF/Dual06 PRTF03 SNF/NF/Distinct07 X-Ray04 SNF08 OPT/SP | 09 ESRD 10 NF 11 ICF/III 12 RHC | 13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE | FISCAL YEAR ENDING DATE: (L35) 09/30 |
| 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 165 (L18) | 10.THE FACILITY IS CERTIFIED A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC | | And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code | 6. Scope of Services Limit 7. Medical Director |
| 13.Total Certified Beds 165 (L17) | B. Not in Compliance with Prog Requirements and/or Applied | | * Code: A | (L12) |
| 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 165 | ICF IID | | 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): | (L15) |
| (L37) (L38) (L39) | (L42) (L43) | | | |
| 16. STATE SURVEY AGENCY REMARKS (IF APPLICA | ABLE SHOW LTC CANCELLATION | DATE): | | |
| 17. SURVEYOR SIGNATURE | Date : | | 18. STATE SURVEY AGENCY | APPROVAL Date: |
| Eva Loch, Unit Supervisor | 05/26/2018 | (L19) | Kamala Fiske-Downing, | Enforcement Specialist 05/26/2018 (L20) |
| PART II - TO BE | COMPLETED BY HCFA R | EGIONA | L OFFICE OR SINGLE S | |
| 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21) | 20. COMPLIANCE WIT RIGHTS ACT: | 'H CIVIL | | ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) > : |
| 22. ORIGINAL DATE 23. LTC AGREE | MENT 24. LTC AGREE | MENT | 26. TERMINATION ACTION | (L30) |
| OF PARTICIPATION BEGINNING 06/01/1981 | G DATE ENDING DA | ΥТЕ | VOLUNTARY0001-Merger, Closure | 05-Fail to Meet Health/Safety |
| (L24) (L41) | (L25) | | 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination | |
| | VE SANCTIONS n of Admissions: (L44) | | 04-Other Reason for Withdrawal | 0 <u>THER</u> 07-Provider Status Change 00-Active |
| (L27) B. Rescind S | uspension Date: (L45) | | | |
| 28. TERMINATION DATE: 29 | 9. INTERMEDIARY/CARRIER NO. | | 30. REMARKS | |
| | 03001 | | | |
| (L28) | | (L31) | | |
| 31. RO RECEIPT OF CMS-1539 32 | 2. DETERMINATION OF APPROVA | L DATE | | |

(L33)

DETERMINATION APPROVAL

(L32)



CMS Certification Number (CCN): 245235 May 25, 2018

Mr. Michael Karel, Administrator Woodbury Health Care Center 7012 Lake Road Woodbury, MN 55125

Dear Mr. Karel:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 21, 2018 the above facility is certified for:

165 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 165 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 25, 2018

Mr. Michael Karel, Administrator Woodbury Health Care Center 7012 Lake Road Woodbury, MN 55125

RE: Project Number S5235029

Dear Mr. Karel:

On April 27, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 12, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 24, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 12, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 21, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 12, 2018, effective May 21, 2018 and therefore remedies outlined in our letter to you dated April 27, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File

| DEPARTMENT OF | | | | CEDTIEL | | | | DICARE & MEDI | CAID SERVICES |
|--|-------------------------|--------------|--|---------------------------------------|-------------------------------|-------------------------------|---|---|--|
| | | | ARE/MEDICAII TO BE COMPL | | | | | | ID: QPXY Facility ID: 00803 |
| MEDICARE/MEDICAID (L1) 245235 2.STATE VENDOR OR ME (L2) 662675000 | PROVIDER NO. | | 3. NAME AND AD (L3) WOODBUR (L4) 7012 LAKE (L5) WOODBUR | DRESS OF FAC Y HEALTH C ROAD | CILITY | TER | .6) 55125 | TYPE OF ACT Initial Termination Validation | 2 |
| 5. EFFECTIVE DATE CHA (L9) 05/01/2007 | | HIP (L34) | 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual | , | GORY 09 ESRD 10 NF | 13 PTIP | (L7) 22 CLIA | 7. On-Site Visit 8. Full Survey Aft | 9. Other |
| DATE OF SURVEY ACCREDITATION STAT 0 Unaccredited 2 AOA | | (L10) | 03 SNF/NF/Distinct 04 SNF | 07 X-Ray 08 OPT/SP | 10 NF 11 ICF/IID 12 RHC | 14 CORF 15 ASC 16 HOSPI | CE | FISCAL YEAR END 09/30 | DING DATE: (L35) |
| 11LTC PERIOD OF CERT. From (a) : To (b) : 12.Total Facility Beds | IFICATION | (L18) | 10.THE FACILITY A. In Complian Program Re Compliance 1. Ac | nce With quirements | AS: | 2. | pproved Waivers Of Technical Personnel 24 Hour RN 7-Day RN (Rural SN | 7. Medical I | Services Limit Director |
| 13.Total Certified Beds | 165 (| . , | X B. Not in Com Requirements | pliance with Prog and/or Applied V | 0 | 5. * Code: | Life Safety Code B * | 9. Beds/Roo (L12) | m |
| 14. LTC CERTIFIED BED E | BREAKDOWN | | | | | 15. FACILI | TY MEETS | | |
| 18 SNF 18 | 8/19 SNF 165 | 19 SNF | ICF | IID | | 1861 (e) (| 1) or 1861 (j) (1): | (L15) | |
| (L37) | (L38) | (L39) | (L42) | (L43) | | | | | |
| 16. STATE SURVEY AGEN | NCY REMARKS (IF A | APPLICA | BLE SHOW LTC CA | NCELLATION | DATE): | | | | |
| 17. SURVEYOR SIGNATU | JRE | | Date : | | | 18. STATE | SURVEY AGENCY | APPROVAL | Date: |
| Sheryl Reed, H | IFE NE II | | 0. | 5/11/2018 | (L19) | <u>Kamala F</u> | iske-Downing, | Enforcement Spe | <u>cialis</u> t 05/25/2018 (L20) |
| | PART II - T | O BE (| COMPLETED B | BY HCFA RE | EGIONAI | OFFICE | OR SINGLE S | TATE AGENCY | |
| DETERMINATION OF 1. Facility is E 2. Facility is r | Eligible to Participate | | | PLIANCE WITH TS ACT: | H CIVIL | | | ncial Solvency (HCFA-2. bl Interest Disclosure Stn e : | |
| | | (L21) | | | | | | | |
| 22. ORIGINAL DATE | 23. LTC | AGREEN | IENT 24 | . LTC AGREEN | MENT | 26. TERM | INATION ACTION: | | (L30) |
| OF PARTICIPATION 06/01/1981 | BEC | GINNING | DATE | ENDING DA | TE | VOLUNTAI 01-Merger, 0 | Closure | 05-Fail t | J <u>NTARY</u> o Meet Health/Safety |
| (L24) | (L41 | 1) | | (L25) | | | action W/ Reimburs | | o Meet Agreement |
| 25. LTC EXTENSION DAT | | | VE SANCTIONS | | | | nvoluntary Termination ason for Withdrawal | OTHER | ider Status Change |
| | (1.27) | - | of Admissions: spension Date: | (L44) | | | | 07-Pion 00-Activ | - |
| | | | NITED (PDI / DY/ | (L45) | | 20 8534-5 | NKC . | | |
| 28. TERMINATION DATE | : | 29 | . INTERMEDIARY/ | UAKRIER NO. | | 30. REMAR | (KS | | |
| | (L28) | | 03001 | | (L31) | | | | |
| 31. RO RECEIPT OF CMS- | 1539 | 32 | DETERMINATION | OF APPROVAL | DATE | | | | |

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improvingthe Health of All Minnesotans

Certified Mail Number: 7015 1730 0001 7737 0274 April 27, 2018

Mr. Michael Karel, Administrator Woodbury Health Care Center 7012 Lake Road Woodbury, MN 55125

RE: Project Numbers S5235029, H5235090, H5235089, H5235088, H5235086

Dear Mr. Karel:

On April 12, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567 whereby corrections are required. In addition, at the time of the April 12, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5235090, H5235089, H5235086 that were found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor Metro A Survey Team 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: susie.haben@state.mn.us Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 22, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 July 12, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 12, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Metatylan

Michaelyn Bruer, Enforcement Specialist Minnesota Department of Health Health Regulation Division Program Assurance Unit phone 651-201-4117 fax 651-215-9697 email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File

| DEPART | MENT OF HEALTH | AND HUMAN SERVICES | | | 1 | | APPROVED |
|--------------------------|---|--|--------------------|-----|---|--------|----------------------------|
| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | - | | 0 | MB NO. | 0938-0391 |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | COM | E SURVEY IPLETED |
| | | 245235 | B. WING | | | | C 12/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | 1 | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE (| CENTER | | | 012 LAKE ROAD VOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | EC | 000 | | | |
| F 000 | Emergency Prepare conducted on 4/9 th recertification surve | iance with CMS Appendix Z edness Requirements was nrough 4/12, 2018, during a ey. The facility is in compliance Z Emergency Preparedness | FC | 000 | | | |
| | through April 12, 20 were also complete survey, H5235086, | rvey was conducted April 9th 018. Complaint investigations ad at the time of the standard H5235088, H5235089 and restigated and found to be | | | | | |
| | as your allegation of Department's accept enrolled in ePOC, y at the bottom of the | f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. | | | | | |
| F 561 SS=D | on-site revisit of you validate that substa | acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with | F 5 | 561 | | | 5/21/18 |
| | promote and facilita through support of not limited to the rig (1) through (11) of t | e right to and the facility must ate resident self-determination resident choice, including but ghts specified in paragraphs (f) this section. | | | | | |
| | | DER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | | TITLE | | (X6) DATE |
| Electron | ically Signed | | | | | | 05/04/2018 |

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.

| | | AND HUMAN SERVICES | | | | FORM | APPROVED |
|---------------|--|--|--------------|------|--|---------|--------------------|
| | | | | TIDI | | | 0938-0391 |
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | E SURVEY PLETED |
| | | | AL DOILD | | | (| C |
| | | 245235 | B. WING | | | | - 12/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE C | ENTER | | | 012 LAKE ROAD | | |
| WOODD | | | | V | VOODBURY, MN 55125 | | |
| (X4) ID | | | ID | v | | | (X5) COMPLETION |
| PREFIX TAG | | ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | | DATE |
| | | | | | DEFICIENCY) | | |
| = = = + | | | | | | | |
| F 561 | Continued From pa | ge 1 | F 5 | 61 | | | |
| | 8492.10(f)(1) The r | anidant has a right to shappa | | | | | |
| | | esident has a right to choose s (including sleeping and | | | | | |
| | | th care and providers of health | | | | | |
| | | stent with his or her interests, | | | | | |
| | assessments, and papplicable provision | olan of care and other | | | | | |
| | applicable provision | is of this part. | | | | | |
| | §483.10(f)(2) The re | esident has a right to make | | | | | |
| | | cts of his or her life in the | | | | | |
| | facility that are sign | ificant to the resident. | | | | | |
| | 8483 10(f)(3) The r | esident has a right to interact | | | | | |
| | | e community and participate in | | | | | |
| | community activities | s both inside and outside the | | | | | |
| | facility. | | | | | | |
| | 8483 10(f)(8) The r | esident has a right to | | | | | |
| | | activities, including social, | | | | | |
| | | nunity activities that do not | | | | | |
| | | hts of other residents in the | | | | | |
| | facility. | NT is not met as evidenced | | | | | |
| | by: | | | | | | |
| | Based on interview | and document review, the | | | This plan and response to these su | | |
| | | ure 1 of 3 residents (R128) | | | findings are written solely to mainta | | |
| | more than once a w | s had the opportunity to bathe | | | certification in the Medicare and Me programs. These written response | | |
| | | | | | not constitute an admission of | 5 00 | |
| | Findings include: | | | | noncompliance with any requirement | | |
| | D100 | | | | an agreement with any findings. W | | |
| | | to the facility on 8/29/17, and nimum data set (MDS) | | | to preserve our rights to dispute the findings in their entirety at anytime a | | |
| | | 3/19/18, was assessed to be | | | any legal action. | | |
| | | l (brief interview for mental | | | , | | |
| | status score of 5). F | R128 was interviewed | | | It is the policy of Woodbury Health | | |
| | | nember (F)-E. During | | | Center (WHCC) to promote and fac | ilitate | |
| | | at 6:22 p.m., F-E was asked R128 to make choices that | | | resident self determination through support of resident choice, including | g but | |

Facility ID: 00803

If continuation sheet Page 2 of 34

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FC | ORM A | 05/25/201 APPROVEI 0938-039 |
|--------------------------|--|--|--------------------|-----|---|--|-----------------------------------|
| STATEMEN | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | 3) DATE COMF | SURVEY PLETED |
| | | 245235 | B. WING | | | C 04/1 |) 2/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | ST | I TREET ADDRESS, CITY, STATE, ZIP CODE | 04/1 | 2/2010 |
| WOODB | URY HEALTH CARE C | ENTER | | - | 012 LAKE ROAD VOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) COMPLETION DATE |
| F 561 | about bathing choic offered a choice of when R128 was ad resident all resident shower day. F-E sa extra shower, as all weekly shower. Wh preferences, F-E sa or more showers ea desire for R128 to b showers a week wh Review of the facilit Daily and Activity Pr revealed a section t Preferences. Accor resident was asked how important is it t tub bath, shower, b R128's response w Important." The ass question about freq During interview on licensed practical n about the process f bathing preferences completed initial ad newly admitted resi whether the admiss the residents' prefe bathing. LPN-C ver day was based on t and said if someon another shower, sta but explained that th assigned initially by | he resident. When asked les, F-E said R128 was not bathing frequency. F-E said mitted, staff informed the is had an assigned weekly id R128 was not offered an residents had an assigned en asked about R128's past aid that R128 used to take two ach week. F-E expressed a be able to have at least two ille at the facility. y's assessment, Interview for references dated 9/1/17, itled, Interview for Daily ding to the assessment, the , "While you are in this facility o you to choose between a ed bath, or sponge bath?" as documented as, "Very sessment did not include a | F 5 | 561 | not limited to the right to choose activit schedules and health care consistent to his/her interests, assessments and pla- care. Plan of correction for residents cited we this survey: R128 was interviewed by the RN Mana- to ensure that care is provided per the resident s instruction, choice and individual preferences. R128 s plan of care was updated per resident s interview directives. The care plan changes were communicated to the st Plan to address/prevent this deficiency other residents: A 72 hour team based admission conference will be held for all admission Bathing preferences will be discussed the resident and/or their representative the meeting. Preferences will be further expanded upon during the Community Life (CL) interview for daily preference assessment. Existing residents will be re-assessed for their bathing preferences at the time of their next scheduled RAI/MDS assessment using the CL interview for daily preferences assessment. The residents plan of c will be updated with the preferences, a needed. Care plan changes are communicated to the staff as changes made. Measures put in place to prevent recurrence: Audits of the 72 hour team based admission conference assessment and | with an of vith ager of taff. y for ons. with e at er / es ce as are as are | |

Facility ID: 00803

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| | | AND HUMAN SERVICES | | | | FORM | 05/25/2018 APPROVED 0938-0391 |
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| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | COM | E SURVEY PLETED |
| | | 245235 | B. WING | ì | | | C 1 2/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | 0-1/ | 2/2010 |
| WOODB | URY HEALTH CARE (| CENTER | | | 7012 LAKE ROAD NOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 561 | During interview on registered nurse (R process for assigni on a resident's roor acknowledged assi shower schedule be did not seem to be A policy regarding a | to be completed in a day. 4/12/18, at 2:56 p.m., N)-F was asked about the ng one shower a week based m number. RN-F gning residents a weekly ased solely on room number | F | 561 | the CL interview for daily preference assessment will be conducted by the Director or designee and CL Director designee for 25% of the newly adm residents weekly x 3 months to ensi- promote and facilitate resident self-determination. A new CL intervi- daily preferences assessment will be conducted for all long term resident during their next scheduled RAI/MD assessment to ensure their preferen- are known and honored. Monthly re- of audit findings at QAPI meetings of audits continuing as warranted. Plan to Monitor: Audits of the 72 hour team based admission conference assessment the CL interview for daily preference assessment will be conducted by the Director or designee and CL Director designee for 25% of the newly adm residents weekly x 3 months to ensi- residents weekly x 3 months to ensi- resident self-determination. A new 0 interview for daily preferences assessment, to promote and facilita- resident self-determination. A new 0 interview for daily preferences assessment will be conducted for a term residents during their next sch RAI/MDS assessment to ensure the preferences are known and honore Monthly review of audit findings at 0 meetings with audits continuing as warranted. Responsible for maintaining compli- LSW Director or designee/RN Manager 0 | and es LSW or or itted ure, iew for be so Sonces with and es LSW or or itted ure the mented ate CL II long eduled eir d. QAPI ance: mity Life | |

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| | - | | | | | FORM | APPROVED 0938-0391 | |
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| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE COM | E SURVEY PLETED | |
| | | IDENTIFICATION NUMBER: A. BU 10ER OR SUPPLIER 245235 B. WII IDER OR SUPPLIER HEALTH CARE CENTER IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IP Intinued From page 4 IP curacy of Assessments R(s): 483.20(g) IP 33.20(g) Accuracy of Assessments. IP e assessment must accurately reflect the ident's status. IP is REQUIREMENT is not met as evidenced IP assed on interview and document review, the ility failed to accurately code the Minimum ta Set (MDS) assessment for 1 of 3 residents 123) reviewed for falls. dings include: 23's Admission Record indicated R123 had gnoses including Alzheimer's disease, anxiety order, major depression, legal blindness, betes mellitus and repeated falls. 23's annual MDS dated 3/21/18, failed to surately reflect falls with or without minor/major ury. The 3/21/18 MDS was coded to indicate 23 had experienced one fall with no injury, two more falls with minor injury and two or more s with major injury from falls since admission prior assessment, whichever was more ently related to a fall. 23's progress note dated 1/6/18, at 4:34 p.m., luded: " Resident found laying [lying] on right e in her bathroom. 1.5 cm (centimeters) X 0.2 laceration to right occipital area. Bleeding | | | | | C 4/12/2018 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| WOODB | URY HEALTH CARE C | ENTER | | | 12 LAKE ROAD OODBURY, MN 55125 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFI) TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 561 F 641 | | - | F 5 F 6 | | Designee | | 5/21/18 | |
| SS=D | CFR(s): 483.20(g) §483.20(g) Accurac The assessment m resident's status. This REQUIREMEN by: Based on interview facility failed to accu Data Set (MDS) ass (R123) reviewed for Findings include: R123's Admission F diagnoses including disorder, major dep diabetes mellitus ar R123's annual MDS accurately reflect fa injury. The 3/21/18 R123 had experience or more falls with m falls with major injury or prior assessment recently related to a R123's progress no included: " Reside side in her bathroor cm laceration to rigl controlled. Dressed kerlex Control blee checks and vitals. N | ey of Assessments. ust accurately reflect the NT is not met as evidenced and document review, the urately code the Minimum sessment for 1 of 3 residents r falls. Record indicated R123 had a Alzheimer's disease, anxiety ression, legal blindness, ad repeated falls. S dated 3/21/18, failed to Ils with or without minor/major MDS was coded to indicate ced one fall with no injury, two inor injury and two or more ry from falls since admission t, whichever was more a fall. te dated 1/6/18, at 4:34 p.m., ent found laying [lying] on right n. 1.5 cm (centimeters) X 0.2 | | | It is the policy of WHCC that assessments must accurately reflect resident s status. Plan of correction for residents cited this survey: R123 s annual MDS assessment of 3/21/18 has been modified and sub to accurately reflect falls. Plan to address/prevent this deficie other residents: The MDS Nurses were re-educated verifying all data that is auto-filled electronically from a previous asses and on the correct encoding of falls ensure accuracy. The falls log will b cross referenced by the MDS Nurse their monthly RAI/MDS schedule to ensure all falls are captured. The M Nurses audited residents that fell th quarter to ensure encoding of falls of correct. Measures put in place to prevent recurrence: The MDS Nurses were re-educated verifying all data that is auto-filled electronically from a previous asses and on the correct encoding of falls of correct. | d with dated omitted ency for d on ssment to be e with IDS he last was | 5/21/10 | |

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| TATEMEN | T OF DEFICIENCIES DF CORRECTION | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | (X3) DAT | 0938-039 E SURVEY | |
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| | | 245235 | B. WING | u | | C 12/2018 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 12/2010 | |
| WOODB | URY HEALTH CARE (| CENTER | | 7012 LAKE ROAD WOODBURY, MN 55125 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETIO DATE | |
| F 641 | the evening shift" R123's progress no included: "Resident hourly rounds. Res in her room next to denies hitting head R123's progress no included: "At 20:04 found on the floor in face down. L (left) of lce pack on L eye . An incident report f included: "Resident floor with her pants hitting head, denies On 4/12/18, at 12:4 (RN)-D verified after that the annual MD had not been coder falls. RN-D stated t MDS because R12 without injuries, two no falls with major major injury section previous MDS. According to the Lo Resident Assessme version 3.0 dated C documented injury was recognized wit hours to a few days the fall Determin | lent through the remainder of bete dated 1/14/18, at 6:26 a.m., t found on the floor during last ident was lying on her left side her bed. No injuries noted, and denies pain" bete dated 1/20/18, at 9:58 p.m., (8:04 p.m.) resident was n her room near the commode, eye and surrounding swollen " or R123 dated 2/22/18, t was found on her bathroom half down. Resident denies | F 64 | 1 ensure accuracy. The falls log wil cross referenced by the MDS Nur their monthly RAI/MDS schedule ensure all falls are captured. Plan to monitor: The MDS Nurses will conduct an each picking 3-4 residents RAI/M assessments from another floor of month, cross referencing the fall I comparing the encoding of falls x months to ensure accuracy and compliance. Audit findings will be reviewed at monthly QAPI meetin audits continuing as warranted. Responsible for maintaining comp MDS Nurses/DON or designee | se with to audit by DS each og and 3 gs with | | |

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| STATEMENT | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIP | LE CONSTRUCTION | | TE SURVEY |
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| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | à | COI | MPLETED |
| | | 245235 | B. WING | | 04 | C / 12/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI | | /12/2010 |
| WOODB | URY HEALTH CARE (| CENTER | | 7012 LAKE ROAD WOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| F 641 | the level of fall-relat fall only once. If the in a single fall, code injury" | A or Scheduled PPS) and code ted injury for each. Code each resident has multiple injuries the fall for the highest level of | | | | |
| F 656 SS=D | Develop/Implement CFR(s): 483.21(b)(| t Comprehensive Care Plan 1) | F 656 | | | 5/21/18 |
| | implement a compr care plan for each r resident rights set f §483.10(c)(3), that objectives and time medical, nursing, a needs that are iden assessment. The c describe the followi (i) The services tha or maintain the resi physical, mental, ar required under §48 (ii) Any services tha under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized rehabilitative servic provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation v resident's represen | t are to be furnished to attain dent's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the | | | | |

Facility ID: 00803

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM / | APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | (X3) DATE COMF | SURVEY PLETED |
| | | 245235 | B. WING _ | | 04/1 |) 2/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE C | ENTER | | 7012 LAKE ROAD WOODBURY, MN 55125 | | |
| | | TEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTION | 1 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | BE | (X5) COMPLETION DATE |
| F 656 | (B) The resident's p future discharge. Fa whether the resider community was ass local contact agenc entities, for this purp (C) Discharge plans plan, as appropriate requirements set fo section. This REQUIREMEN by: Based on observat review, the facility fa address the use of for 1 of 1 resident (I) Findings include: On 4/10/18 at 9:43 interview she had b from hitting the grat upper thighs. R58 p and small dark colo On 4/12/18 at 9:58 resting in bed, cove breakfast tray was o when a staff nurse I R58 was complainin staff nurse removed leg. R58's upper rig several small disco size on the leg. R5 noted to have a sca marks. | oreference and potential for acilities must document acilities must document acilities must document at's desire to return to the sessed and any referrals to ies and/or other appropriate pose. Is in the comprehensive care an accordance with the rth in paragraph (c) of this NT is not met as evidenced ation, interview and document ailed to develop a care plan to an anticoagulant with bruising | F 65 | It is the policy of WHCC to develop implement a comprehensive person-centered care plan for each resident. Plan of correction for residents cited this survey: An immediate investigation was conducted to rule out maltreatment regards to R58 s bruises and subr to MDH 4/10/18 Incident Tracking #312437. No maltreatment was suspected. R58 was experiencing a increase in hallucinations, at which R58 thrashes about in bed and wheelchair. R58 bruises easily due daily anticoagulant therapy. R58 ha history of persistent visual, auditory tactile hallucinations. R58 s care p has been updated to reflect increase potential for bruising /bleeding as reto the daily anticoagulant use. Plan to address/prevent this deficie other residents: All residents on anticoagulant thera their care plans reviewed and updated to reflect increase other residents: | d with in nitted an time; to s a and lan ed elated ncy for py had | |

Facility ID: 00803

| | | | | | | 0938-039 |
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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | E SURVEY PLETED |
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| | | 245235 | B. WING _ | | 04/ | 12/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE (| CENTER | | 7012 LAKE ROAD WOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETIOI DATE |
| F 656 | Continued From pa | ge 8 | F 65 | 56 | | |
| | 8/5/17, indicated R a BIMS (brief interv 14, indicating cogni further indicated R and indicated R and indicated R s review of physician order for eliquis (a l administered orally The care plan, last R 58 had diagnoses history of cerebral i The care plan failed potential bruising as used, nor did the ca | | | needed, by the RN Managers, to their potential for bruising/bleeding result of the anticoagulant use. Measures put in place to prevent recurrence: The nurses were re-educated on to accurately assess and care pla potential for bruising/bleeding for residents on anticoagulant therap Plan to Monitor: All newly admitted/re-admitted reswill be audited for anticoagulant use the RN Managers to ensure that a plan is developed to address thei potential risk for bruising/bleeding | g as a the need in the those y. sidents se by a care | |
| F 677 SS=D | urine, etc). On 4/12/18, at 11:5 (RN)-H stated she reports regarding b R58 had self report RN-H verified no in the care plan regar- use of the anticoag ADL Care Provided CFR(s): 483.24(a)(§483.24(a)(2) A res- out activities of dail services to maintain personal and oral h This REQUIREMEN by: Based on observat review, the facility f | 8 a.m. registered nurse was unaware of any incident ruising for R58. RN-H verified ed the bruise on her hand. terventions were included in ding the frequent bruising or ulant. for Dependent Residents 2) sident who is unable to carry y living receives the necessary n good nutrition, grooming, and | F 67 | x 3 months. Audit findings will be at monthly QAPI meetings and co warranted. Responsible for maintaining com RN Mangers or designee/DON or designee/Staff Development | neviewed ontinue if pliance: | 5/21/18 |

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| STATEMENT | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | 0938-039 SURVEY PLETED |
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| | | IDENTIFICATION NUMBER. | A. BUILDI | ING | | | |
| | | 245235 | B. WING | | | | _ 2/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | · | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| WOODB | URY HEALTH CARE | CENTER | | - | 012 LAKE ROAD VOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 677 | Continued From pa | - | F 6 | 77 | | | |
| | living, received bat assistance with inc | hing/hygiene assistance and ontinence care. | | | resident self determination through support of resident choice, includin not limited to the right to choose ac | g but tivities, | |
| | Findings include: R111's admission minimum data set (MDS) | | | | schedules and health care consistent his/her interests, assessments and care. | | |
| | cognitively intact, to more staff for trans required extensive staff for personal h R111 was coded as assessment refere | 1/18/18, indicated R111 was otally dependent on two or iferring between surfaces and assistance from two or more ygiene. According to the MDS, s not having bathed during the nce period. | | | Plan of correction for residents cite this survey: R128 was interviewed by the RN M to ensure that care is provided per resident's instruction, choice and individual preferences. R128's plar care was updated per resident's int directives. The care plan changes | RN Manager d per the and s plan of t's interview | |
| | interview she was u enough, and was u day. R111 stated st at night at times, at to the late hour. R1 be bathed at least | not being bathed frequently insure of her scheduled bath raff had asked her to bathe late nd stated she had refused due 11 reported she felt she should weekly. | | care was updated per resident's interdirectives. The care plan changes we communicated to the staff. Plan to address/prevent this deficient other residents: A 72 hour team based admission conference will be held for all admission Bathing preferences will be discussed | | ency for ssions. sed with | |
| | interview, R111 sta for 3 weeks. R111 under my arms" an smelled of feces. D | 5 a.m., during a follow up ated she had not been bathed stated, "I smell all the time id also stated she thought she During the interview, R111's hair bily and damp, and R111 did | | | the resident and/or their representa the meeting. Preferences will be fu expanded upon during the Commu Life (CL) interview for daily prefere assessment. Existing residents will re-assessed for their bathing prefe at the time of their next scheduled RAI/MDS assessment using the CI | rther nity nces be rence | |
| | manager (RN)-E, r bath the previous v offered. RN-E state bath on their scheo | a.m. the registered nurse/unit eported R111 had refused her week due to the late hour it was ed when a resident refused a luled weekly bath day, another be offered that week. | | | interview for daily preferences assessment. The residents' plan of will be updated with the preference needed. Care plan changes are communicated to the staff as chan- made. | s, as | |
| | On 4/12/18 at 12:2 | 9 p.m., R111 was observed nair matted to her head. | | | Made. Measures put in place to prevent recurrence: | | |

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| | | AND HUMAN SERVICES | | | | FORM | 05/25/2018 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245235 | B. WING | | | (04/* |) 12/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | • ., | |
| WOODB | JRY HEALTH CARE (| CENTER | | | 012 LAKE ROAD VOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 677 | no direction related undated nursing as R111 required assis and bed mobility, an transferring with a f plan also indicated bathed on Monday R111's 30 day bathi revealed R111 was assistance during b On 4/2/18 and 4/9/1 indicated R111 had evening hours. No a were documented a R111's Progress No provided no further refusals or opportun The facility's Standa revised 4/26/17, dir scheduled. Weekly bath or shower. Thi hairs (men or those shop). Use of deod dry skin areas. Nail more often as need provided by the lice resident's care plan tub bath." R103 was continua | st revised on 2/5/18, included to bathing assistance. R111's sistant care plan, indicated stance of 2 staff for bathing nd 2 staff assistance with ull mechanical lift. The care R111 was scheduled to be afternoons. ing record was reviewed and totally dependent on staff for pathing on 3/19 and 3/26/18. 18, the documentation refused a bath during the other bathing opportunities as offered. otes dated 3/1 to 4/12/18, information related to bathing nities. ards of Care Guidelines last ected staff: "Bath/showers as minimum of complete tub is includes body, nails, ears, e women not going to beauty orant to underarm. Lotion to s are to be trimmed weekly or led. (Diabetic nail care is to be insed staff). Bed bath per i f unable to tolerate shower or | F 6 | 577 | Audits of the 72 hour team based admission conference assessment the CL interview for daily preference assessment will be conducted by th Director or designee and CL Director designee for 25% of the newly adm residents weekly x 3 months to ens promote and facilitate resident self-determination. A new CL intervi daily preferences assessment will be conducted for all long term resident during their next scheduled RAI/ME assessment to ensure their prefere are known and honored. Monthly re of audit findings at QAPI meetings audits continuing as warranted. Plan to Monitor: Audits of the 72 hour team based admission conference assessment the CL interview for daily preference assessment will be conducted by th Director or designee and CL Director designee for 25% of the newly adm residents weekly x 3 months to ens residents' preferences were docum during the interviews/conference ar assessment, to promote and facilitat resident self-determination. A new of interview for daily preferences assessment will be conducted for a term residents during their next sch RAI/MDS assessment to ensure the preferences are known and honore Monthly review of audit findings at 0 | es he LSW or or itted ure, iew for be ts DS nces eview with and es he LSW or or itted ure the ented hd ate CL II long heduled eir d. | |
| | 4:41 p.m., R103 wa Broda chair in the d | a. (2 hours 42 minutes). At as observed to be sitting in a lining room. At 7:05 p.m., ted to his room after the meal, | | | meetings with audits continuing as warranted. Responsible for maintaining compli | ance: | |

| | COF DEFICIENCIES | & MEDICAID SERVICES | (X2) MUI | TIPL | E CONSTRUCTION | | 0938-039 |
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| | OF CORRECTION | IDENTIFICATION NUMBER: | | | | | PLETED |
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| | | 245235 | B. WING | | | 04/1 | 2/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE | CENTER | | | 012 LAKE ROAD VOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI) TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETIC DATE |
| F 677 | Continued From pa | • | F 6 | 77 | | | |
| | the foot of the bed At 7:21 p.m., NA-C checked for inconti appeared tired, and prior to the start of stated R103 had no | oda chair, was positioned by by nursing assistant (NA)-B. verified R103 had not been nence. NA-C stated R103 d confirmed R103 had been up his shift at 2:30 p.m. NA-C ot been checked for the start of the shift. | | | LSW Director or designee/Commu Director or designee/ RN Manager Designee | | |
| | 4/10/18, from 9:03 hours 49 minutes). sitting in a wheelch observation period by staff to check R p.m. NA-A and NA- an EZ stand (mech NA-E confirmed R ⁻ and bladder. During p.m., R103's incom | observations of R103 on a.m. through 12:52 p.m. (3 R103 was observed to be hair. During the continuous , there were no attempts made 103 for incontinence. At 12:52 •E transferred R103 to bed with hanical lift). Both NA-A and 103 was incontinent of bowel g the observation at 12:52 tinent pad was observed to be amount of feces, and was e. | | | | | |
| | 4/10/18, multiple st director, music the (RN)-C, licensed p nursing assistants | ous observation time on aff including the memory care rapist, registered nurse ractical nurse (LPN)-B and (NA-A, NA-B, NA-C, NA-D, past R103 without offering the | | | | | |
| | | 7 p.m., NA-A verified R103 had for incontinence since that mately 8:00 a.m. | | | | | |
| | admitted to the fac including: anxiety d | record revealed R103 was ility 6/7/17, with diagnosis lisorder, major depressive fective) disorder, Parkinson's | | | | | |

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| DEPART CENTEF | FORM | APPROVED 0938-0391 | | | | | |
|--------------------------|--|--|--------------------|---|--|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE | E SURVEY PLETED |
| | | 245235 | B. WING | | · | | C |
| NAME OF F | PROVIDER OR SUPPLIER | 245255 | D. WING | | STREET ADDRESS, CITY, STATE, ZIP CODE | 04/ | 12/2018 |
| | | | | | 7012 LAKE ROAD | | |
| WOODB | URY HEALTH CARE C | ENTER | | ١ | WOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| TAG F 677 | Continued From pa disease and demen A quarterly Minimur assessment dated 3 required extensive a transfers and toiletii R103 was always in frequently incontine for Mental Status (E 99 indicating the rea assessed. A Care Area Assess included: " requir with all activities of mobility, and "is at r integrity and UTI's (infections)". R103's care plan da "requires assist of t upon rising, before and during night rou Assistant Assignme guidance for staff. On 4/11/18 at 11:20 expectation is nursi [R103's] plan of car The facility's policy Evaluation dated 20 each resident's con appropriate treatme assist residents in r highest practicable | ge 12 ntia with behavior disturbance. In Data Set (MDS) 3/14/18, indicated R103 assist of two with bed mobility, ng. The MDS further indicated incontinent of bladder, and int of bowel. A Brief Interview BIMS) score was recorded as sident was unable to be sement (CAA) dated 9/19/17, es extensive to total assist daily living (ADL's) and isk for alteration in skin | F | | DEFICIENCY) | RIATE | DATE |
| | infections, and pron | note a resident's | | | | | |

If continuation sheet Page 13 of 34

| | - | | | | | FORM | APPROVED 0938-0391 |
|-----------|---|---|----------------|------------------|---|---|----------------------------|
| STATEMENT | WOODBURY HEALTH CARE CENTER 7012 LAKE ROAD WOODBURY, MN 55125 (X4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN- (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN- (EACH DEFICIENCY MIST AG F 686 SS=D Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(1)(10) F 686 F 686 SS=D CFR(s): 483.25(b)(1)(1)(10) F 686 F 686 Notestand Sased 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 document review, the facility failed to ensure 1 of 3 residents (R103) identified at risk for pressure ulcers (PU) received timely repositioning. It is the policy of WHC residents identified as ulcers receive timely r Plan of correction for r this survey: R103 was continually observed on 4/9/18, from 4:41 p.m., R103 was observed to be sitting in a Broda chair in the dining room. At 7:05 p.m., R103 was transported to his room after the meal, and R103 in the Broda chair, was positioned by the foot of the bed by nur | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED | | |
| | | 245235 | B. WING | | | | C 12/2018 |
| NAME OF F | PARTMENT OF HEALTH AND HUMAN SERVICES FOO NITERS FOR MEDICARE & MEDICAID SERVICES OMB1 NUMARY STEMENT OF DEFICIENCIES (X3) MULTIFLE CONSTRUCTION ILAN OF CORRECTION (X1) PROVIDER/SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ODBURY HEALTH CARE CENTER DID ID SUMMARY STATEMENT OF DEFICIENCIES ILD SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ILE CH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOLD BE CROBES SHOLD BE CROBS ABLEFERENCED TO THE APPROPRIATE DEFICIENCY) 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer F 686 S-Based on the comprehensive assessment of a resident, the facility must ensure that: F 686 VID A resident with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers from develop ing. F 686 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R103) identified at risk for pressure ulcers (PU) received timely repositioning. Findings include: Findings include: Plan of correction for residents cited with this survey; R103 was continually observed on 4/9/18, from 4:41 p.m 7:23 p.m. (2 hours 42 minutes). At Plan of correction for mesidents cited with this surve | | | | | | |
| WOODBU | WOODBURY HEALTH CARE CENTER | | | | | | |
| PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | BE | (X5) COMPLETION DATE |
| | CFR(s): 483.25(b)(1) §483.25(b) Skin Inte §483.25(b)(1) Press Based on the comp resident, the facility (i) A resident receive professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer with professional sta- promote healing, pr new ulcers from dev This REQUIREMEN by: Based on observat review, the facility fa (R103) identified at received timely repo Findings include: R103 was continual 4:41 p.m., R103 wa Broda chair in the d R103 was transport and R103 in the Brot the foot of the bed b At 7:21 p.m., NA-C repositioned. NA-C and confirmed R103 start of his shift at 2 | 1)(i)(ii) egrity sure ulcers. rehensive assessment of a must ensure that- es care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition hey were unavoidable; and oressure ulcers receives at and services, consistent andards of practice, to event infection and prevent veloping. NT is not met as evidenced ion, interview and document ailed to ensure 1 of 3 residents risk for pressure ulcers (PU) ositioning. | F 6 | 886 | It is the policy of WHCC to ensure residents identified as at risk for pre- ulcers receive timely repositioning. Plan of correction for residents cited this survey: R103 s Comprehensive skin and positioning evaluation was reassess 5/2/18 with no changes noted from 3/12/18 assessment. R103 s plan was reviewed with the NAR s by th Manager to ensure timely reposition R103 experienced no adverse consequences as a result of the cite practice and continues to be free of | essure d with sed on of care le RN hing. ed skin | 5/21/18 |
| | shift. | | | | The RN Managers have reviewed a residents listed as at risk on the | .11 | |

Facility ID: 00803

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | APPROVEI 0938-039 |
|--------------------------|--|--|---------------------|---|--|---------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | E SURVEY PLETED |
| | | 245235 | B. WING _ | | | C 12/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, S | STATE, ZIP CODE | |
| WOODB | URY HEALTH CARE (| CENTER | | 7012 LAKE ROAD WOODBURY, MN 551 | 125 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFERENC | PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY) | (X5) COMPLETIO DATE |
| F 686 | F 686 Continued From page 14 During continuous observations of R103 on 4/10/18, from 9:03 a.m. through 12:52 p.m. (3 hours 49 minutes). R103 was observed to be sitting in a wheelchair. During the continuous observation period, there were no attempts made by staff to reposition R103. At 12:52 p.m. NA-A and NA-E transferred R103 to bed with an EZ stand (mechanical lift). Both NA-A and NA-E confirmed R103 was incontinent with bowel and bladder.During the observation at 12:52 p.m., R103's incontinent pad was observed to be soiled with a small amount of feces, and was saturated with urine. R103's coccyx was noted to be slightly reddened, and the skin appeared wrinkled with no open areas noted. During the continuous observation time on 4/10/18, multiple staff including the memory care director, music therapist, registered nurse (RN)-C, licensed practical nurse (LPN)-B and | | F 6 | comprehensive sk evaluation assess timely repositionin the individualized communicated to their plan of care. Measures put in p recurrence: Re-education was staff to review the positioning and fo to prevent the dev ulcers. A weekly a identified as being comprehensive sk evaluation assess by the RN manage | blace to prevent s provided to the nursing importance of timely llowing the plan of care velopment of pressure audit of 3-4 residents g at risk per their kin and positioning sment will be conducted | |
| | nursing assistants (and NA-E) walked p resident any care in On 4/10/18 at 12:47 not been offered to morning at approxin she did not know w R103. R103's admission r admitted to the faci including: anxiety d disorder, mood (affed disease and dement A quarterly Minimur assessment dated a | (NA-A, NA-B, NA-C, NA-D, bast R103 without offering the including repositioning. 7 p.m., NA-A verified R103 had be repositioned since that mately 8:00 a.m. NA-A said hy she had not repositioned ecord revealed R103 was lity 6/7/17, with diagnosis isorder, major depressive ective) disorder, Parkinson's ntia with behavior disturbance. | | review of audit fine with audits continu Plan to Monitor: A weekly audit of as being at risk pe skin and positionin assessment will b managers x 3 mon repositioning and ulcer developmen audit findings at C audits continuing a | dings at QAPI meetings uing as warranted. 3-4 residents identified er their comprehensive ng evaluation be conducted by the RN nths to ensure timely avoidance of pressure it. Monthly review of QAPI meetings with as warranted. naintaining compliance: esignee/DON or | |

Facility ID: 00803

If continuation sheet Page 15 of 34

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
|--------------------------|--|---|--------------------|-----|---|----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | LE CONSTRUCTION | (X3) DAT | E SURVEY PLETED |
| | | | A. BUILD | ING | | С | |
| | | 245235 | B. WING | | | 04/ | 12/2018 |
| | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODBI | JRY HEALTH CARE C | ENTER | | | VOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | R103 was always in frequently incontine for Mental Status (E 99 indicating the res assessed. A Care Area Assess | ng. The MDS further indicated incontinent of bladder, and int of bowel. A Brief Interview BIMS) score was recorded as sident was unable to be sment (CAA) dated 9/19/17, | F 6 | 86 | | | |
| | included: " requir with all activities of | es extensive to total assist daily living (ADL's) and isk for alteration in skin | | | | | |
| | "Encourage repositi rounds and every 2 care plan indicated, impairment to skin i | ated 7/3/17, directed staff, ion/position changes during hours as able." The 11/16/17 [R103] has potential integrity due to impaired poor appetite, use of hence" | | | | | |
| | | ng Assistant Assignment Sheet Q2H (reposition every two If two)" | | | | | |
| F 688 SS=D | expectation is nursi [R103's] plan of car reposition resident of | ecrease in ROM/Mobility | F 6 | 888 | | | 5/21/18 |
| | resident who enters range of motion doe | acility must ensure that a the facility without limited es not experience reduction in ess the resident's clinical | | | | | |

Facility ID: 00803

If continuation sheet Page 16 of 34

| | | AND HUMAN SERVICES | | | | FORM / | APPROVED |
|-------------------|----------------------------------|--|--------------|----|--|-----------|--------------------|
| | | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (XO) MU | | E CONSTRUCTION | (X3) DATE | 0938-0391 |
| | OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER: | | | | | PLETED |
| | | | | | | C | |
| | | 245235 | B. WING | | | | 2/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE O | ENTER | | | 012 LAKE ROAD | | |
| | | | | N | /OODBURY, MN 55125 | | |
| (X4) ID PREFIX | | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL | ID PREFIX | ~ | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETION |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | ^ | CROSS-REFERENCED TO THE APPROPR | | DATE |
| | | | | | DEFICIENCY) | | |
| F 688 | | | | ~~ | | | |
| Г 000 | Continued From pa | • | F 6 | 88 | | | |
| | of motion is unavoid | ates that a reduction in range | | | | | |
| | | | | | | | |
| | | ident with limited range of | | | | | |
| | | propriate treatment and | | | | | |
| | | e range of motion and/or to rease in range of motion. | | | | | |
| | | rease in range of motion. | | | | | |
| | | ident with limited mobility | | | | | |
| | | e services, equipment, and | | | | | |
| | | ain or improve mobility with icable independence unless a | | | | | |
| | | is demonstrably unavoidable. | | | | | |
| | This REQUIREMEN | NT is not met as evidenced | | | | | |
| | by: | | | | | | |
| | | ion, interview and document ailed to ensure staff | | | It is the policy of WHCC that reside with limited mobility receive approp | | |
| | | y walking program as | | | services, equipment and assistance | | |
| | | herapy, for 1 of 1 resident | | | maintain or improve mobility with | , 10 | |
| | (R128) reviewed for | r mobility. | | | maximum practicable independenc | е | |
| | Findings includes | | | | unless unavoidable. | | |
| | Findings include: | | | | Plan of correction for residents cite | d with | |
| | R128's admission r | ecord face sheet indicated an | | | this survey: | | |
| | admission date of 8 | 3/29/17. R128's face sheet | | | R128 s walking program was verif | ied | |
| | | including generalized muscle | | | with the Director of Therapy and | م الج ر | |
| | | coordination, repeated falls, leg below knee. A Minimum | | | communicated to the nursing staff RN Manager. R128 s care plan wa | | |
| | | sessment dated 3/19/18, | | | updated to ensure the walking prog | | |
| | | s cognitively impaired with a | | | was current and correct. R128 did | | |
| | | w for mental status) score of 5. | | | experience any adverse consequer | ices as | |
| | On 1/0/10 + 6.14 - | m D100 was shoomed lying | | | a result of the cited practice. | | |
| | | .m., R128 was observed lying family member (F)-E. A | | | Plan to address/prevent this deficie | ncy for | |
| | | observed propped against the | | | other residents: | | |
| | wall behind the hea | d of the bed. Although a | | | All residents receiving nursing resto | orative | |
| | | ng the resident, R128's lower | | | services have had their programs | | |
| | | ed to be absent below the about whether R128 received | | | reviewed by the RN Managers and Restorative Aide to ensure that the | | |
| 1 | KINGO, WYIIGH ASKEU | | 1 | | i colorativo muo to ensure triat trie | | |

Facility ID: 00803

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| | | & MEDICAID SERVICES | | | | | 0938-039 |
|--------------------------|--|---|--------------------------------------|----|--|---|---------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION (X | COMF | SURVEY PLETED |
| | | 245235 | B. WING | | | 04/1 | ; 2/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 0-1/1 | 2/2010 |
| WOODB | URY HEALTH CARE (| CENTER | 7012 LAKE ROAD WOODBURY, MN 55125 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETIO DATE |
| F 688 | Continued From pa | lge 17 | F 6 | 88 | | | |
| | supposed to walk w through Friday. F-E each weekday, and leading to a decline confirmed R128 ha | staff, F-E stated staff were with R128 daily Monday E stated staff did not do this I was concerned that it was a in R128's mobility. F-E d a prosthetic lower left leg, | | | therapy established programs are be carried out as recommended. Measures put in place to prevent recurrence: The RN Managers will review all new | 1 | |
| | reported staff had r walk with R128 eac resident was weake explained that R128 the hallway and bac "today [R128] felt w | help to apply it. F-E further not routinely been offering to th day and so F-E thought the er now than before. F-E 8 used to be able to walk down ck without a break but said, yeak and needed to stop and | | | restorative programs and/or changes programs as they are handed off by therapy. The RN Managers will communicate the new programs or existing program changes to the nurs staff at daily stand-up meetings and update the plan of care. Nursing staff | sing f | |
| | weakness and impa and range of motion amputation with pro- included increasing and mobility, and us increase R128's inc daily living. One of 9/6/17, and revised | the hall." evealed the resident had airment in walking, balance, in due to a left below knee osthesis. The care plan goals is the current level of function sing adaptive devices to dependence with activities of the interventions, initiated on 4/12/18, included a walking te with assist of one staff | | | were re-educated on the process for implementing new restorative programs and/or changing existing programs handed off by therapy to ensure that residents receive appropriate service equipment and assistance to improve maintain their mobility. Plan to Monitor: The RN Managers or designee will an residents per week x 3 month that are restorative programs to ensure the pl implemented, documented, care plan | ms es, e or udit 3 e on lan is nned | |
| | assistant (NA)-F wa programming at the therapy created res residents, such as o range of motion exe nursing assistants, nursing assistant, w the restorative prog NA-F said some da participate which w | 4/11/18 at 6:52 a.m., nursing as asked about the restorative e facility. NA-F explained how storative programs for daily walking programs or ercises. NA-F said all the along with the restorative vorked together to carry out grams ordered for residents. tys residents refuse to as within their rights, but NA-F cplain the benefits of | | | and occurring on the floor. Monthly re of audit findings at QAPI meetings wi audits continuing as warranted. Responsible for maintaining compliar RN Mangers or designee/DON or designee/Restorative Aide | ith | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED . 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|------|----------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIP | PLE CONSTRUCTION | | E SURVEY |
| | F CORRECTION | IDENTIFICATION NUMBER: | | | | | IPLETED |
| | | | | | | | С |
| | | 245235 | B. WING | | | 04/ | 12/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE C | ENTER | | | 7012 LAKE ROAD | | |
| | | | | | WOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 688 | Continued From pa | - | F 6 | 888 | 3 | | |
| | again later in the da | ould re-approach the resident ay. NA-F said would always tell refused to participate, and | | | | | |
| | supposed to docum | nursing assistants were nent daily in the nursing rehab electronic medical record | | | | | |
| | (eMR). NA-F said the clearly designate date | nere were different options to aily in the nursing rehab task if | | | | | |
| | | o participate, if a resident was e resident participated for the | | | | | |
| | requested for the m and April 2018. Stat | ng Rehab Task record was onths of February, March, if provided the record for dates which showed the following: | | | | | |
| | on 12/23 days; R12 days; R128 was not and staff document days. It was unclear for the daily walking | ocumentation, R128 walked 8 refused to walk on 8/23 t available to walk 1/23 days; ed "Not Applicable" on 4/23 r what "Not Applicable" meant program. There were 7 days tion at all, March 23, 24, 25 d 8, 2018. | | | | | |
| | On 4/11/18, at 9:16 bed. R128 stated he sometimes, and co | a.m., R128 was observed in e liked to go for walks nfirmed the choice was up to how often staff offered to help go for a walk, R128 | | | | | |
| | R128's walking prog assistants were not right now, because walking and an ank | p.m., NA-G was asked about gram. NA-G said nursing supposed to walk with R128 R128 was having issues with le rolling. NA-G added that nursing assistant and staff | | | | | |

Facility ID: 00803

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| | | AND HUMAN SERVICES | | | | FORM | APPROVED |
|---------------|----------------------|---|---------------|------|--|----------|---------------------|
| | | & MEDICAID SERVICES | | | | | . 0938-0391 |
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | | E SURVEY IPLETED |
| | | | A. DOILD | inte | G | | С |
| | | 245235 | B. WING | | | | 12/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | <u> </u> | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| WOODB | URY HEALTH CARE C | TENTER | | I | 7012 LAKE ROAD | | |
| WOODD | | | | | WOODBURY, MN 55125 | | |
| (X4) ID | | | ID | | PROVIDER'S PLAN OF CORRECTIO | | (X5) COMPLETION |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIZ TAG | | (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF | | DATE |
| | | | | | DEFICIENCY) | | |
| | | | | | | | |
| F 688 | | • | F 6 | 386 | 8 | | |
| | | epartment were supposed to | | | | | |
| | | 28. At 2:01 p.m. NA-F said, ant is able to walk with [R128]" | | | | | |
| | , , | current order from therapy | | | | | |
| | | walk with R128 once a day, 7 | | | | | |
| | | een 100-200 feet. NA-F | | | | | |
| | | day there was a question | | | | | |
| | | erved walking concern, and aited for physical therapy to | | | | | |
| | | king for safety before | | | | | |
| | continuing the walk | ing program. However, NA-F | | | | | |
| | | ven staff verbal confirmation | | | | | |
| | | ants were safe to continue the | | | | | |
| | | s ordered, every day. At 2:06 128 about going for a walk, | | | | | |
| | and R128 agreed. | 120 about yoing for a wait, | | | | | |
| | - | | | | | | |
| | | p.m., R128 was observed | | | | | |
| | | with NA-F, using a walker. ed R128 with a wheelchair in | | | | | |
| | | eeded to sit and rest. After | | | | | |
| | | of the hall, R128 turned | | | | | |
| | around to walk back | k, but stopped to rest in the | | | | | |
| | | uple minutes. At 2:27 p.m. | | | | | |
| | | d walked about 110 feet so | | | | | |
| | | g before finishing the walk a current nursing assistant | | | | | |
| | | cabinet, and reviewed it for | | | | | |
| | R128's restorative p | program. NA-F confirmed the | | | | | |
| | | am of 100-200 feet was listed | | | | | |
| | | and said that should happen , including weekends. | | | | | |
| | Seven days a week | , including weekends. | | | | | |
| | On 4/11/18 at 2:37 | p.m., R128 had finished | | | | | |
| | walking and was re | sting in bed visiting with F-E. | | | | | |
| | | he resident was feeling, R128 | | | | | |
| | | od today. R128 acknowledged | | | | | |
| | able to walk without | E stated R128 was previously tresting. | | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | 05/25/2018 APPROVED 0938-0391 |
|---------------|--|--|---------------|--|-----------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | IPLE CONSTRUCTION | (X3) DATE | E SURVEY |
| AND PLAN O | FCORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | NG | | PLETED |
| | | 245235 | B. WING _ | | | C 12/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | · [| STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODB | JRY HEALTH CARE C | CENTER | | 7012 LAKE ROAD WOODBURY, MN 55125 | | |
| (X4) ID | | | ID | | | (X5) COMPLETION |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | | DATE |
| | | | ı | | | |
| F 688 | Continued From pa | ge 20 | F 68 | 38 | | |
| | On 4/11/18 at 2:42 | p.m., the director of therapy | | | | |
| | (DT) was interviewe | ed about R128's restorative | | | | |
| | | T said nursing assistants fer to walk R128 every day. | | | | |
| | The DT said R128 d | does refuse to walk at times, | | | | |
| | | should still offer daily. In d there was a day or two | | | | |
| | | may have been waiting to hear | | | | |
| | | to walk with R128, but stated 128 to be safe, and expected | | | | |
| | the walking program | n to continue as | | | | |
| | | described a time when R128 own the hall and back without | | | | |
| | stopping, but said F | R128 has had multiple | | | | |
| | | ce January 2018, and therapy e some decline due to that. | | | | |
| | On 4/12/18 at 3:14 | p.m., registered nurse (RN)-F | | | | |
| | confirmed that if the | erapy wrote a recommendation | | | | |
| | walk the resident se | ay, then staff should offer to even days a week. | | | | |
| | A policy regarding r | ehabilitative nursing programs | | | | |
| | was requested, but | not provided. | | | | |
| F 761 SS=E | Label/Store Drugs a CFR(s): 483.45(g)(I | | F 76 | 51 | | 5/21/18 |
| 33=L | ., | | | | | |
| | | g of Drugs and Biologicals als used in the facility must be | | | | |
| | labeled in accordan | ce with currently accepted | | | | |
| | appropriate access | les, and include the orv and cautionary | | | | |
| | instructions, and the | e expiration date when | | | | |
| | applicable. | | | | | |
| | §483.45(h) Storage | of Drugs and Biologicals | | | | |
| | | | | | | |

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| | | & MEDICAID SERVICES | 1 | | OMB NO. | |
|--------------------------|-----------------------|---|---------------------|---|----------------|---------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | | E SURVEY PLETED |
| | | 245235 | B WING | | | |
| | PROVIDER OR SUPPLIER | 243235 | D. WING | STREET ADDRESS, CITY, STATE, ZIP CO | | 12/2018 |
| | | | | 7012 LAKE ROAD | | |
| WOODB | URY HEALTH CARE (| CENTER | | WOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETIC DATE |
| F 761 | Continued From pa | ae 21 | F 7 | 61 | | |
| 1 /01 | | cordance with State and | Г / | 61 | | |
| | | acility must store all drugs and | | | | |
| | biologicals in locked | d compartments under proper | | | | |
| | | ls, and permit only authorized | | | | |
| | personnel to have a | access to the keys. | | | | |
| | §483.45(h)(2) The f | acility must provide separately | | | | |
| | locked, permanentl | y affixed compartments for | | | | |
| | | d drugs listed in Schedule II of | | | | |
| | | Prug Abuse Prevention and and other drugs subject to | | | | |
| | | n the facility uses single unit | | | | |
| | package drug distri | bution systems in which the | | | | |
| | | inimal and a missing dose can | | | | |
| | be readily detected. | NT is not met as evidenced | | | | |
| | by: | I is not met as evidenced | | | | |
| | Based on observat | ion, interview and document | | It is the policy of WHCC to e | | |
| | | ailed to ensure medications | | maintain accurate labeling a | | |
| | | beled properly for 5 of 14 2, R67, R58 and R118) | | of medications that have not | expired. | |
| | reviewed for medica | | | Plan of correction for resider | nts cited with | |
| | | | | this survey: | | |
| | Findings include: | | | R80, R12, R67, R58 and R1 | | |
| | During observation | s of multiple medication | | identified medications imme discarded, replaced and pro | | |
| | | ighout the facility, medications | | No resident identified experi | | |
| | for R80, R12, R67, | R58 and R118, which included | | adverse consequences as a | | |
| | | pen/vial medications, lacked | | cited practice. | | |
| | | nen they were opened, or ns expired. In addition, an | | Plan to address/prevent this | deficionay for | |
| | | missing the order label. | | other residents: | denciency ior | |
| | | C C | | An audit of all resident medi | | |
| | | n storage on second floor on | | conducted by the RN Manag | | |
| | | n., with licensed practical long-term care second floor | | and correct any medications expired or require dates whe | | |
| | | observed to have the following | | ensure compliance. Those c | | |
| | expired insulin avai | lable for use stored in the | | compliance were removed, o | discarded, | |
| | treatment cart: | | 1 | replaced and properly labele | . d | |

Facility ID: 00803

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| CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235 NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER | | (X1) PROVIDER/SUPPLIER/CLIA | R/CLIA (X2) MULTIPLE CONSTRUCTION | | | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C 04/12/2018 | |
|--|--|--|--------------------------------------|---|---|--|--|
| | | | | | | | |
| | | | STREET ADDRESS, CITY, STATE, ZIP COD | | | | |
| | | | 7012 LAKE ROAD WOODBURY, MN 55125 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETIO DATE | |
| F 761 | opened on 2/24/18 was identified as of R12's Lantus insul it had been opened At 10:39 a.m on 4/ Aerosol inhaler for but not dated as to At 10:41 a.m., LP be labeled and sto would remove the new inhaler from th During observation of the medication s care unit (TCU)on 10:44 a.m., two Ac R58 were observe were undated as to RN-A verified med stored properly an undated inhalers fu update the directo During observation TCU cart on 4/11/- insulin flexpen was was dated 3/8/18. on the insulin pen. Novolog flexpen, b lacked an approprivould remove the replace it with ano medication room r | ulin vial was identified as B. R80's Lantus Solution pen pened on 1/22/18. in pen was undated as to when d for use. (11/18, an Advair Diskus R67 was observed to be open, when it had been put into use. N-A verified medications should red properly. LPN-A stated she inhaler and replace it with a he medication storage room. Ins with registered nurse (RN)-A storage cart on the transitional the first floor, on 4/11/18 at lvair Diskus Aerosol inhalers for d to be opened for use, but to when opened. At 10:47 a.m., ications should be labeled and d stated she would remove the rom the medication cart and r of nursing (DON). Ins with RN-B of the lower level 18 at 11:07 a.m., a Novolog s observed to be opened, and it However, there was no label RN-B stated it was R118's put verified the insulin pen iate label. RN-B stated she insulin pen from use and ther insulin flex pen from the | F 76 | Measures put in place to prevere recurrence: The policy and procedure for m storage and labeling was revie remains current and up to date staff that administer medication been re-educated on the policy procedure. Medication and tre carts will be inspected weekly Managers or designee to ensu- compliance. Plan to Monitor: RN Mangers or designee will of weekly audits of 1 medication for medication or treatment cart m Monthly review of audit finding meetings with audits continuing warranted. Responsible for maintaining co RN Managers or designee/Nut that administer medication/DO designee | edication wed and . Nursing n have v and atment by the RN re onduct room and 1 onthly x 3. s at QAPI g as ompliance: sing staff | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 05/25/2018 APPROVED 0938-0391 | |
|-----------------------------|--|---|--|--|--|-----------------|-------------------------------------|--|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | |
| 245235 | | | B. WING | | | C 04/12/2018 | | |
| NAME OF | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | • | | |
| WOODBURY HEALTH CARE CENTER | | | 7012 LAKE ROAD WOODBURY, MN 55125 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFI) TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 761 F 812 SS=E | URY HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 addressed, and she would pull medications from use as necessary, contact the pharmacy and get replacements. In addition, the DON stated as soon as replacement medications arrived, she'd ensure they were appropriately labeled before putting them into circulation. The facility's policy and procedure STORAGE OF MEDICATION dated April 2014, included: "Outdated, contaminated or deteriorated medications, and those in containers that are cracked, soiled, or without secure closures, are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists." The facility's policy and procedure MEDICATION LABELS dated June 2015, included:"G. Under no circumstances are unattached labels requested or accepted from the pharmacy. Only the pharmacy may place a label on the medication container. I. Medication containers having soiled, damaged, incomplete, illegible, confusing, or makeshift labels are removed from the medication supply and destroyed in accordance with the medication destruction policy. If the medication is a current order, a refill supply is ordered from the pharmacy." Food Procurement,Store/Prepare/Serve-Sanitary | | F 7 | | | | 5/21/18 | |

Facility ID: 00803

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| CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULT | OMB NO. 0938-039 (X3) DATE SURVEY | | |
|--|---|--|--------------------------------------|--|---|
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | IG | COMPLETED |
| 245235 | | B. WING _ | | C 04/12/2018 | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CO | - |
| WOODB | URY HEALTH CARE (| CENTER | | 7012 LAKE ROAD WOODBURY, MN 55125 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY) | SHOULD BE COMPLETION |
| F 812 | Continued From pa | ge 24 | F 81 | 2 | |
| | (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document | | | It is the policy of WHCC to a | |
| | dried prior to storing supplements were the potential to imp | ailed to ensure dishes were air g, and failed to ensure dated when thawed. This had act all six residents residing on 10 residents who received nents. | | and distribute food in accord professional standards for for safety. Plan of Correction for issues survey: | ood service |
| | kitchenettes were to | p.m. the kitchen and unit oured. Two dietary aides | | Undated food items were im disposed of. Dishwashing s immediately re-educated to dish machine policy. No res adversely affected by this cit | taff were the company idents were |
| | from the clean side putting them in stor the plate holder, put in the drawers, stac of dry racks of cups metal carts and sta At that time, the die this finding, noting of DM stated dishes w and added she'd put | vere observed grabbing dishes of the dish machine and rage wet, stacking plates wet in tting wet scoops and utensils cking racks of wet cups on top s, stacking wet bowls in the cking wet trays in floor carts. etary manager (DM) confirmed drops of water on dishes. The vere supposed to be air dried, urchased a special product for ensure quick drying. DA-B | | Plan to address/prevent this other residents: All dietary staff were re-educ company dish machine polic procedure. This dish machi be part of the new staff orier dietary staff were re-educate company supplement labelir policy. The closing checklis to include nightly inspections kitchenette refrigerators for | cated on by and ne policy will ntation. All ed on the ng and dating t was updated s of the |

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| ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | | MB NO. 0938-039 (X3) DATE SURVEY | | |
|--|--|--|---------|--------------------------------------|---|-------------------------|---------------------------|
| | | A. BUILDI | | COMPLETED | | | |
| | | | B. WING | | | С | |
| | | B. WING | | TREET ADDRESS, CITY, STATE, ZIP CODE | 04/12/2018 | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | D12 LAKE ROAD | | |
| WOODB | URY HEALTH CARE | CENTER | | | /OODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | K | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) DMPLETIOI DATE |
| F 812 | Continued From pa | age 25 | F 8 | 12 | | | |
| 1 012 | verified she was trained to put the dishes away dry. The DM stated the dishes being stacked wet | | 10 | 12 | labeling and dating of food items. | | |
| | who received room refrigerators revea supplements thaw orange supplement and 3rd floor: 2 pro- undated. According containers, staff we supplements more The DM confirmed been dated when t The facility's Dishn included: "air-dry a wet items." The facility's Food included: "Each lat information: produc or identifying descri | ents residing on the lower level in trays. A tour of the unit led: 1st floor: 5 orange ed and undated, 2nd floor: 4 its stored thawed and undated, otein shakes stored thawed and g to directions on the ere not to serve the than 14 days after thawed. I the supplements should have aken out to thaw. Inachine Policy dated 6/15/17, Il items. Do not stack or nest Labeling policy dated 6/15/17, pel must contain the following ct name (or a common name ription), use by date, date the red or opened, time prepared | | | Plan to Monitor: RD/FSD will conduct random audits/observation weekly x3/months o dishwashing, drying and storing of dish RD/FSD will perform audits of unit refrigerators weekly x3/months to assu stored food items comply with the company labeling and dating policy. FSD/RD will audit weekly x3/months supplements leaving the kitchen are labeled and dated according got compa labeling and dating policy. All audit findings will be reported on at the mont QAPI meeting. Responsible for maintaining complianc RD and FSD | es. re Iny nly | |
| F 880 SS=D | | | F 8 | 80 | | 5/2 | 21/18 |
| | infection prevention designed to provid comfortable enviro | stablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable | | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 05/25/2018 APPROVED 0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE | E SURVEY PLETED |
| | | 245235 | B. WING | | | | C 12/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE C | ENTER | | | 012 LAKE ROAD NOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 880 | program. The facility must es and control program a minimum, the follo §483.80(a)(1) A sys reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the p but are not limited to (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tra to be followed to pro- (iv)When and how i resident; including to (A) The type and du depending upon the involved, and (B) A requirement the least restrictive pos circumstances. (v) The circumstance must prohibit emploid disease or infected | tablish an infection prevention n (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; iom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a | Fε | 380 | | | |

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| | | & MEDICAID SERVICES | | | | | 0938-039 |
|--------------------------|---|---|---------------------|----|--|-------|----------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION (X3 | , | SURVEY |
| | | | A. BOILDI | | | С |) |
| | | 245235 | B. WING _ | | | 04/1 | 2/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE (| CENTER | | | 012 LAKE ROAD VOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) COMPLETION DATE |
| F 880 | Continued From pa contact will transmi | t the disease; and | F 8 | 80 | | | |
| | by staff involved in | ne procedures to be followed direct resident contact. | | | | | |
| | | stem for recording incidents facility's IPCP and the aken by the facility. | | | | | |
| | | ndle, store, process, and as to prevent the spread of | | | | | |
| | IPCP and update th | eview. duct an annual review of its heir program, as necessary. NT is not met as evidenced | | | | | |
| | review, the facility f spead of infection r cleansing of a blood | tion, interview and document ailed to minimize the risk for elated to the handling and d glucose meter (device used s) for 1 of 1 (R118) resident | | | It is the policy of WHCC to minimize t risk for spread of infection related to handling and cleaning blood glucose meters. | the | |
| | reviewed. Findings include: | | | | Plan of correction for residents cited v this survey: LPN-A was immediately re-educated of the proper handling and cleaning of th | on | |
| | (LPN)-A was observing wiped R118's finger R118's finger with a | p.m., licensed practical nurse ved to wear gloves when she r with an alcohol wipe, poked a single use lancet, obtained a | | | blood glucose meter. R118 experience no observable adverse consequence result of the cited practice. | ed | |
| | drop of blood with a glucometer to deter LPN-A then put the plastic container of | a test strip she inserted into the mine blood sugar results. used glucometer on top of the single use unused lancets. hitizing wipe around the | | | Plan to address/prevent this deficienc other residents: Re-education was provided to the nur staff that performs blood glucose chec via a meter to ensure that the risk to | rsing | |
| | glucometer and let minutes, however, | the wrap did not cover the eter, including the end where | | | spread infection is minimized as related handling and cleaning of the blood glucose meters. | ed to | |

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| | | & MEDICAID SERVICES | | | | 0938-039 |
|--------------------------|---|---|---------------------|--|---|---------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | COM | SURVEY |
| | | 245235 | B. WING | | (04 /1 | ; 2/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE (| CENTER | | 7012 LAKE ROAD WOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETIO DATE |
| F 880 | Continued From pa | age 28 iserted. LPN-A wiped the | F 880 | | | |
| | glucometer for abo medication cart. Im the glucometer out request and confirm acknowledged the and said that was " lancets would need On 4/12/18 at 3:15 nursing and registe dirty glucometer sh clean lancets and t thoroughly cleaned glucometers were u The facility's Blood revised 9/2017, inc Use a Sani-Cloth S from container. b) meter c) If wipe is v excess so as not to code ports during of keeping the glucom Sani-Wipe is 2 min glucometer remains down for two full m wipe after thorough full minutes place the | ut 10 seconds and put it in mediately after, LPN-A took of the medication cart upon ned it was not still wet. LPN-A glucometer was on the lancets not good." LPN-A then said the | | Measures put in place to prevent recurrence: Re-education was provided to the m staff that performs blood glucose ch via a meter to ensure that the risk to spread infection is minimized as rel handling and cleaning of the blood glucose meters. RN Managers will conduct weekly audits observing nu handling and cleaning blood glucos meters during use on 3-4 residents week x 3 months. Monthly review o findings at QAPI meetings with aud continuing as warranted. Plan to Monitor: RN Managers will conduct weekly a observing nurses handling and clean blood glucose meters during use or residents per week x 3 months. Mo review of audit findings at QAPI me with audits continuing as warranted Responsible for maintaining compli RN Managers or designee/Nurses to perform blood glucose checks via meter/Infection Preventionist/DON of designee | necks ated to arses e per f audit its nudits uning n 3-4 nthly etings ance: that | |
| F 883 SS=D | | imococcal Immunizations 1)(2) | F 883 | 3 | | 5/21/18 |
| | immunizations §483.80(d)(1) Influe | za and pneumococcal enza. The facility must develop dures to ensure that- | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 05/25/2018 APPROVED 0938-0391 |
|--------------------------|---|---|-------------------|-----|---|------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATI COM | E SURVEY PLETED |
| | | 245235 | B. WING | | | | C 12/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| WOODB | URY HEALTH CARE C | ENTER | | | 7012 LAKE ROAD NOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 883 | each resident or the receives education potential side effect (ii) Each resident is immunization Octob annually, unless the contraindicated or t immunized during th (iii) The resident or has the opportunity (iv)The resident's m documentation that following: (A) That the resider was provided educa and potential side e immunization; and (B) That the resider immunization or did immunization due to refusal. §483.80(d)(2) Pneu must develop polici that- (i) Before offering th immunization, each representative rece benefits and potent immunization; (ii) Each resident is immunization, unles medically contraind already been immu (iii) The resident or has the opportunity | The influenza immunization, be resident's representative regarding the benefits and is of the immunization; offered an influenza ber 1 through March 31 e immunization is medically he resident has already been his time period; the resident's representative to refuse immunization; and hedical record includes indicates, at a minimum, the ht or resident's representative ation regarding the benefits effects of influenza th either received the influenza of medical contraindications or imococcal disease. The facility es and procedures to ensure the pneumococcal a resident or the resident's ives education regarding the ial side effects of the offered a pneumococcal as the immunization is icated or the resident has | Fξ | 383 | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FOR | D: 05/25/2018 M APPROVED O. 0938-0391 |
|--------------------------|--|--|-------------------|-----|---|---|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION (X3) D | ATE SURVEY DMPLETED C |
| | | 245235 | B. WING | i | 0 | 4/12/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | |
| WOODB | URY HEALTH CARE (| CENTER | | | 012 LAKE ROAD VOODBURY, MN 55125 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 883 | following: (A) That the resider was provided educa and potential side e immunization; and (B) That the resider pneumococcal imm the pneumococcal imm the pneumococcal contraindication or This REQUIREMEN by: Based on document facility failed to offe to 3 of 5 residents (immunizations. Findings include: The facility's Pneum | indicates, at a minimum, the the or resident's representative ation regarding the benefits offects of pneumococcal the either received the punization or did not receive immunization due to medical refusal. NT is not met as evidenced the review and interview, the r pneumococcal immunization R117, R45, R8) reviewed for mococcal Vaccine Practice | F | 883 | It is the policy of WHCC to offer each resident a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized. Plan of correction for residents cited with this survey: | |
| | "The pneumococca (PPSV23) or pneum (PCV13), is offered age and over at adu given the opportuni choice will be docu Regarding timelines procedure guided older receive a dos of PPSV23 at least continued, "Adults of previously received PPSV23 should rec dose of PCV13 should after receipt of the The procedure requ | edure revised 9/17, included: I polysaccharide vaccine nococcal conjugate vaccine to all residents 65 years of missionThe resident will be ty to refuse the vaccine. The mented in the medical record." s of administration, the 'All adults 65 years of age or e of PCV13 followed by a dose 1 year later." The guidance 55 or older who have not PCV13 and who have one or more doses of ceive a dose of PCV13. The build be given at least 1 year most recent PPSV23 dose." uired orders to be obtained administer the pneumococcal | | | R117, R45 and R8 have been offered pneumococcal immunization and their immunization records have been update None of the identified residents experienced adverse consequences as a result of the cited practice. Plan to address/prevent this deficiency for other residents: The RN Managers will address all newly admitted residents regarding their immunization status at the 72 hour team based admission conference if not established prior to the meeting. The RN Managers will ensure that pneumococca immunization has been offered and that education was provided regarding the benefits and potential side effects of the pneumococcal immunization. The LPN | a or |

Facility ID: 00803

If continuation sheet Page 31 of 34

| | - | AND HUMAN SERVICES | | | PRINTED: FORM OMB NO. | APPROVE |
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| STATEMEN | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
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| | | 245235 | B. WING _ | | | 2/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 | |
| WOODB | URY HEALTH CARE (| CENTER | | 7012 LAKE ROAD WOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHU CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETIO DATE |
| F 883 | The procedure dire determine prior vac (Minnesota Immuni Connection), the re previous long term family/resident inter Review of the immuni medical record rever R117 was admitted had received a hist 2000. There was no pneumococcal vac administered after a R45 was admitted to had received a hist 2014. There was no pneumococcal vac administered after a R8 was admitted to not have any histor immunization histor there was no docur offered or administer after admission. During interview on registered nurse (R the floors were curr immunizations. RN and figure out whic residents had alrea | ain consents when possible. Acted nursing staff to attempt to ccinations history through MIIC ization Information esident's primary care clinic, care facilities, and through rview. unizations tab in the electronic ealed the following: I to the facility on 3/8/18, and orical "Pneumovax Dose 1" in o documentation that a second cination had been offered or admission. to the facility on 10/28/17, and orical "Pneumovax Dose 1" in o documentation that a second cination had been offered or admission. to the facility on 10/28/17, and orical "Pneumovax Dose 1" in o documentation that a second cination had been offered or admission. | F 8 | | admission arding the s and enter edical tab. An tatus was s. sing ata will be cation is s and eumococcal e at the neduled essment at s unization ent ucation on inistering al gers will dents ratus at the lensure on has n was s and eumococcal | |

Facility ID: 00803

If continuation sheet Page 32 of 34

| CENTE | RS FOR MEDICARE | AND HUMAN SERVICES | T | | O | FORM. MB NO. | 05/25/2018 APPROVED 0938-0391 |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | E SURVEY PLETED |
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| NAME OF I | PROVIDER OR SUPPLIER | • | | | TREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| WOODB | URY HEALTH CARE (| CENTER | | | 012 LAKE ROAD /OODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 883 | | age 32 record was incomplete, it was neumococcal vaccination was | F8 | 883 | data regarding the resident s immunization status and enter findi into the resident s medical record the immunization tab. An audit of a term residents pneumococcal immunization status was conducted RN Managers. Residents found to missing pneumococcal immunization will be offered immunization after education is provided regarding the benefits and potential side effects of pneumococcal immunization. This done at the time of the resident s scheduled care conference/RAI/ME assessment and documented in the resident s medical record under the immunization tab. Plan to Monitor: An audit of all long term residents pneumococcal immunization status conducted by the RN managers. The audit will be cross-referenced with the RAI/MDS schedule weekly x 3 mor ensure that the RN managers prov- education regarding the benefits ar potential side effects of the immuni- offer the pneumococcal immunization tab inter all pertinent data into the resi- medical record/immunization tab for residents identified in the audit as h missing pneumococcal immunization data. Audit findings and progress m updating/educating and offering pneumococcal immunization for the residents identified will be presented the monthly QAPI meetings and co- until all long term residents found to missing immunization data have be | under II long d by the having on data e of the will be next DS e ne s was he the oths to ide nd zation, ion and dent s or all naving on hade in ose ed at ntinue o have | |

Event ID:QPXY11

Facility ID: 00803

If continuation sheet Page 33 of 34

| | | AND HUMAN SERVICES | | | | FORM | 05/25/2018 APPROVED 0938-0391 |
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| | F OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | COM | E SURVEY IPLETED |
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| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | 12/2010 |
| WOODB | URY HEALTH CARE | CENTER | | | 012 LAKE ROAD VOODBURY, MN 55125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 883 | Continued From pa | age 33 | F | 883 | offered/educated and documented required. The Infection Prevention audit 10% of newly admitted reside weekly x 3months to ensure comp Monthly review of audit findings at meetings with audits continuing as warranted. Responsible for maintaining comp Infection Preventionist/RN Manage designee/DON or deignee | st will ents liance. QAPI liance: | |

Facility ID: 00803

If continuation sheet Page 34 of 34

| | MENT OF HEALTH | | | F52 | 35028 | FORM | 04/24/2018 APPROVED 0938-0391 |
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| | ROVIDER OR SUPPLIER URY HEALTH CARE | ECENTER | 7012 LA | RESS, CITY, S KE ROAD BURY, MN | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION) | REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BË | (X5) COMPLETION DATE |
| | INITIAL COMMENT A Life Safety Code Minnesota Departm Fire Marshal Divisio (Woodbury Healtho compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I (NFPA) Standard 1 Chapter 19 Existing Woodbury Healtho with no basement. at 2 different times. was constructed in be of Type II(222) of floor addition was of determined to be of Because the origina are of the same typ was surveyed as of The building is prot system. The facility full corridor smoke spaces open to the for automatic fire d | Survey was conduct nent of Public Safety on. At the time of this are Center) was fou a requirements for pa aid at 42 CFR, Subpa ety from Fire, and the Fire Protection Asso 01, Life Safety Code g Health Care. are Center is a 4-sto The building was con The original 3 story 1979 and was deter construction. In 1986 constructed that was f Type II(222) constr al building and the 1 be of construction, th | ed by the - State s survey, nd in articipation art = 2012 ciation e (LSC), ry building mined to building mined to , a fourth uction. addition e facility prinkler stem with coms and conitored m. and had a | K 000 | DEFICIENCY) | | |
| | | | | | | | c |
| LABORATO | RY DIRECTOR'S OR PROV | /IDER/SUPPLIER REPRES | ENTATIVE'S SIG | NATURE | TITLE | | (X6) DATE |

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 1730 0001 7737 0274 April 27, 2018

Mr. Michael Karel, Administrator Woodbury Health Care Center 7012 Lake Road Woodbury, MN 55125

Re: State Nursing Home Licensing Orders - Project Numbers S5235029, H5235090, H5235089, H5235088, H5235086

Dear Mr. Karel:

The above facility was surveyed on April 9, 2018 through April 12, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5235090, H5235089, H5235088, and H5235086 that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Woodbury Health Care Center April 27, 2018 Page 2

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 Susie Haben, Unit Supervisor, at (651) 201-3794 or susie.haben@state.mn.us.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Metatylan

Michaelyn Bruer, Enforcement Specialist Minnesota Department of Health Health Regulation Division Program Assurance Unit phone 651-201-4117 fax 651-215-9697 email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File

| Minneso | ta Department of He | alth | | | | |
|--------------------------|---|--|-----------------------|--|-------------------|--------------------------|
| - | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 00803 | B. WING | | 04/1 | ; 2/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
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| 2 000 | Initial Comments | | 2 000 | | | |
| | ****ATTEI | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | nether a violation has been | | | | |
| | that may result from orders provided tha the Department with | hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance. | | | | |
| | receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a | participate in the electronic nsure orders consistent with artment of Health in 14-01, available at ate.mn.us/divs/fpc/profinfo/inf elicensing orders are | | | | |
| ABORATOR | epartment of Health Y DIRECTOR'S OR PROVIE ically Signed | ER/SUPPLIER REPRESENTATIVE'S SIGI | NATURE | TITLE | | (X6) DATE 05/04/18 |

STATE FORM

| | NT OF DEFICIENCIES I OF CORRECTION | ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 00803 | B. WING | | C 04/12/2018 | | |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| NOODE | URY HEALTH CARE (| renter | KE ROAD URY, MN 5512 | 25 | | | |
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| 2 000 | Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Department's the following correct Please indicate in y correction that you and identify the dat In addition, complat completed at the tin An investigation of H5235088, H52350 completed. The con substantiated. Minnesota Department the State Licensing federal software. Ta assigned to Minness Nursing Homes. The assigned tag m column entitled " If statute/rule out of co "Summary Statement and replaces the "T correction order. The findings which are interesting the state the | Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for i indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 4/12/18, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, e when they will be completed int investigations were also me of the licensing survey. complaints H5235086, 089, and H5235090 were | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | | A. DUILDING | | | С |
| | | 00803 | B. WING | | | 12/2018 |
| IAME OF I | PROVIDER OR SUPPLIER | STREE | T ADDRESS, CITY, | STATE, ZIP CODE | | |
| VOODB | URY HEALTH CARE | CENTER | LAKE ROAD DBURY, MN 55 [.] | 125 | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF C | CORRECTION | (X5) |
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| 2 000 | Continued From pa | age 2 | 2 000 | | | |
| | are the Suggested Time period for Co | Method of Correction and rrection. | | | | |
| | FOURTH COLUM "PROVIDER'S PLA APPLIES TO FEDE | ARD THE HEADING OF TH N WHICH STATES, NN OF CORRECTION." TH ERAL DEFICIENCIES ONLY IR ON EACH PAGE. | IS | | | |
| | PLAN OF CORREC | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS (E STATUTES/RULES. | | | | |
| 2 550 | MN Rule 4658.040 Resident Assessm | 0 Subp. 4 Comprehensive ent; Review | 2 550 | | | 5/21/18 |
| | home must examin quarterly and must comprehensive as | f assessments. A nursing ne each resident at least revise the resident's sessment to ensure the by of the assessment. | | | | |
| | by: Based on interview facility failed to acc | ent is not met as evidenced and document review, the urately code the Minimum sessment for 1 of 3 residen r falls. | | Corrected | | |
| | Findings include: | | | | | |
| | diagnoses including | Record indicated R123 had g Alzheimer's disease, anxie pression, legal blindness, nd repeated falls. | əty | | | |
| | | S dated 3/21/18, failed to alls with or without minor/ma | ajor | | | |

STATE FORM

QPXY11

If continuation sheet 3 of 34

| | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00803 | | | (X3) DATE SURVEY COMPLETED C 04/12/2018 | |
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| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| VOODB | URY HEALTH CARE | CENTER | KE ROAD URY, MN 5512 | 25 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 2 550 | injury. The 3/21/18 R123 had experient or more falls with major inju- or prior assessment recently related to a R123's progress not included: " Resid side in her bathroo cm laceration to rig controlled. Dressed kerlex Control ble checks and vitals. I registered) instruct monitoring on resid the evening shift' R123's progress not included: "Residen hourly rounds. Res in her room next to denies hitting head R123's progress not included: "At 20:04 found on the floor i face down. L (left) Ice pack on L eye . An incident report f included: "Residen floor with her pants hitting head, denies On 4/12/18, at 12:4 (RN)-D verified after that the annual MD had not been code | MDS was coded to indicate inced one fall with no injury, two ninor injury and two or more ary from falls since admission nt, whichever was more a fall. Dete dated 1/6/18, at 4:34 p.m., ent found laying [lying] on right m. 1.5 cm (centimeters) X 0.2 pht occipital area. Bleeding d with gauze and stretch reding and initiate long neuro NARs (nursing assistant ed to complete frequent visual dent through the remainder of ' Dete dated 1/14/18, at 6:26 a.m. t found on the floor during last ident was lying on her left side her bed. No injuries noted, and denies pain" Dete dated 1/20/18, at 9:58 p.m. (8:04 p.m.) resident was n her room near the commode eye and surrounding swollen " for R123 dated 2/22/18, t was found on her bathroom a half down. Resident denies | , , , | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: _ | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | E SURVEY PLETED C | |
|--------------------------|--|--|---------------------------------------|--|---------------------------------|-------------------------|--|
| | | 00803 | B. WING | | 04/ | 04/12/2018 | |
| NAME OF I | PROVIDER OR SUPPLIER | | ADDRESS, CITY, S | TATE, ZIP CODE | | | |
| NOODB | URY HEALTH CARE | | AKE ROAD BURY, MN 5512 | 25 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE | |
| 2 550 | Continued From pa | age 4 | 2 550 | | | | |
| | without injuries, two no falls with major | 3 had experienced two falls o falls with minor injuries and injuries. RN-D indicated the n had been auto filled from a | | | | | |
| | Resident Assessmere version 3.0 dated C documented injury was recognized with hours to a few days the fall Determin occurred since adm assessment (OBR) the level of fall-rela fall only once. If the | ong Term Care Facility ent Instrument User's Manua October 2017, " Any that occurred as a result of, o thin a short period of time (e.g s) after the fall and attributed the number of falls that nission/entry or reentry or prior A or Scheduled PPS) and coo ted injury for each. Code eac e resident has multiple injuries e the fall for the highest level | or g., to or de h s | | | | |
| | The director of nurs review and revise p to ensuring the acc director of nursing system to educate system to ensure c | THOD OF CORRECTION: sing (DON) or designee could policies and procedures relate curacy of assessments. The or designee could develop a staff and develop a monitorin compliance. R CORRECTION: Twenty-on | ed | | | | |
| | (21) days. | | Ŭ | | | | |
| 2 560 | MN Rule 4658.040 Plan of Care; Conte | 5 Subp. 2 Comprehensive ents | 2 560 | | | 5/21/18 | |
| | comprehensive pla objectives and time long- and short-term | of plan of care. The on of care must list measurable tables to meet the resident's m goals for medical, nursing, ychosocial needs that are | | | | | |

If continuation sheet 5 of 34

| STATEMEN | ta Department of He T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
|--------------------------|--|--|---------------------|--|------------------------------------|--|
| | | 00803 | | | 04/12/2018 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AL 7012 LAK | | STATE, ZIP CODE | | |
| NOODB | URY HEALTH CARE (| | JRY, MN 55 | 125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLET | |
| 2 560 | Continued From pa | age 5 | 2 560 | | | |
| | assessment. The of must include the in required by Minnes subdivision 14, par | nprehensive resident comprehensive plan of care dividual abuse prevention plan tota Statutes, section 626.557, agraph (b). ent is not met as evidenced | | | | |
| | by: Based on observat review, the facility f address the use of | ion, interview and document failed to develop a care plan to an anticoagulant with bruising R58) in the sample. | | Corrected | | |
| | Findings include: | Findings include: | | | | |
| | interview she had b from hitting the gra upper thighs. R58 p | a.m., R58 stated during pruises on her right lower arm b bar, and bruises on her pointed to her right upper arm pred spots were observed. | | | | |
| | resting in bed, cove breakfast tray was when a staff nurse R58 was complaini staff nurse remove leg. R58's upper rig several small disco size on the leg. R58 | a.m., R58 was observed ered with blankets. Her on the tray table in front of her brought in her medications. ng of leg discomfort and the d the blanket to assess R58's ght leg was observed to have blored areas, less that 1 cm in i8's right forearm was also attering of small discolored | | | | |
| | admitted to the faci minimum data set (8/5/17, indicated R a BIMS (brief interv 14, indicating cogn | ecord indicated she'd been ility on 7/29/17. The admission (MDS) assessment dated 58 's cognition was intact with view for mental status) score of ition was good. The MDS 58 had no behavioral concerns | | | | |

| | ta Department of He | | | | | | | |
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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SU IDENTIFICATIO | | | E CONSTRUCTION | | E SURVEY PLETED | |
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| | | 00803 | | B. WING | | | 04/12/2018 | |
| AME OF F | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | | |
| VOODBI | URY HEALTH CARE C | CENTER | 7012 LAK WOODBU | E ROAD IRY, MN 551 | 25 | | | |
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| 2 560 | Continued From pa | 000 6 | | 2 560 | DEFICIENC | T) | | |
| 2 300 | • | • | agulant A | 2 300 | | | | |
| | and indicated R58 v review of physician order for eliquis (a l administered orally | orders indicated blood thinner) to | d R58 had an | | | | | |
| | The care plan, last R58 had diagnoses history of cerebral in The care plan failed potential bruising as used, nor did the ca signs/symptoms of urine, etc). | that included h nfarction, and a to indicate a pr a result of the are plan indicate | ypertension, trial fibrillation. roblem of anticoagulant to monitor for | | | | | |
| | On 4/12/18, at 11:5 (RN)-H stated she wareports regarding b R58 had self report RN-H verified no int the care plan regard use of the anticoag | was unaware of ruising for R58. ed the bruise or terventions were ding the frequen | any incident RN-H verified her hand. e included in | | | | | |
| | SUGGESTED MET The director of nurs review and revise p to ensuring the care each individual resi or designee could o staff and develop a staff included individual of care. | sing (DON) or de policies and proc e plan is individu dent. The direc develop a systen monitoring syst | esignee could edures related ialized for tor of nursing n to educate em to ensure | | | | | |
| | TIME PERIOD FOF (21) days. | R CORRECTION | N: Twenty-one | | | | | |
| 2 895 | MN Rule 4658.0528 Motion | 5 Subp. 2.B Reh | ab - Range of | 2 895 | | | 5/21/18 | |
| | Subp. 2. Range of | motion. A supp | ortive program | | | | | |
| | | | | | | | 1 | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00803 | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 04/12/2018 | |
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| AME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| VOODB | URY HEALTH CARE (| CENTER | KE ROAD URY, MN 55 | 125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLET DATE |
| 2 895 | that is directed tow through positioning implemented and n comprehensive res of nursing services development of a n provides that: B. a resident wit receives appropriat increase range of n decrease in range This MN Requirem by: Based on observat review, the facility f implemented a dail recommended by t (R128) reviewed fo Findings include: R128's admission n admission date of 8 revealed diagnoses weakness, lack of 6 and absence of left Data Set (MDS) as indicated R128 was BIMs (brief intervie On 4/9/18 at 6:14 p in bed, visiting with prosthetic leg was 6 weall behind the heat | ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the nursing care plan which tha limited range of motion te treatment and services to notion and to prevent further of motion. ent is not met as evidenced ion, interview and document ailed to ensure staff y walking program as herapy, for 1 of 1 resident | | Corrected | | |

| STATEMEN | ta Department of He T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: _ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C - 04/12/2018 | |
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| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE (| :ENTER | KE ROAD URY, MN 5512 | 25 | | |
| | | | - | 23 PROVIDER'S PLAN OF (| | (VE) |
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| 2 895 | Continued From pa | ige 8 | 2 895 | | | |
| | supposed to walk w through Friday. F-E each weekday, and leading to a decline confirmed R128 ha and required staff had r walk with R128 eac resident was weak explained that R12 the hallway and bad "today [R128] felt w rest halfway down t R128's care plan re weakness and impa and range of motio amputation with pro included increasing and mobility, and u increase R128's ind daily living. One of 9/6/17, and revised program to ambula 100-200 feet daily. During interview on assistant (NA)-F wa programming at the therapy created res residents, such as range of motion ex- nursing assistants, nursing assistant, w | staff, F-E stated staff were with R128 daily Monday E stated staff did not do this I was concerned that it was e in R128's mobility. F-E d a prosthetic lower left leg, help to apply it. F-E further not routinely been offering to ch day and so F-E thought the er now than before. F-E 8 used to be able to walk down ck without a break but said, yeak and needed to stop and the hall." evealed the resident had airment in walking, balance, n due to a left below knee osthesis. The care plan goals the current level of function sing adaptive devices to dependence with activities of the interventions, initiated on 4/12/18, included a walking te with assist of one staff a saked about the restorative e facility. NA-F explained how storative programs for daily walking programs or ercises. NA-F said all the along with the restorative worked together to carry out grams ordered for residents. | | | | |
| | participate which w would then try to ex | ays residents refuse to as within their rights, but NA-F cplain the benefits of rould re-approach the resident | | | | |

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| 2 895 | again later in the da a nurse if residents explained that the r supposed to docum task portion of the e (eMR). NA-F said ti clearly designate da a resident refused ti unavailable, or if the day. A copy of the Nursi requested for the m and April 2018. Sta 3/14/18 - 4/12/18, v According to staff do on 12/23 days; R12 days; R128 was no and staff document days. It was unclea for the daily walking with no documenta and April 2, 4, 7 and On 4/11/18, at 9:16 bed. R128 stated h sometimes, and co | ay. NA-F said would always tel refused to participate, and nursing assistants were nent daily in the nursing rehab electronic medical record here were different options to aily in the nursing rehab task if to participate, if a resident was e resident participated for the ng Rehab Task record was nonths of February, March, ff provided the record for dates which showed the following: documentation, R128 walked 28 refused to walk on 8/23 t available to walk 1/23 days; ted "Not Applicable" on 4/23 r what "Not Applicable" meant g program. There were 7 days tion at all, March 23, 24, 25 | 5 | | | | |
| | responded, "not too On 4/11/18, at 2:00 R128's walking pro assistants were not | go for a walk, R128 o often." p.m., NA-G was asked about gram. NA-G said nursing t supposed to walk with R128 R128 was having issues with | | | | | |
| | walking and an ank only the restorative from the therapy de | Ale rolling. NA-G added that nursing assistant and staff epartment were supposed to 28. At 2:01 p.m. NA-F said, | | | | | |

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| ND PLAN OF CORRECTION | | CATION NUMBER. | A. BUILDING: _ | ····· | | |
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| OODBURY HEALTH | I CARE CENTER | 7012 LAK WOODBU | KE ROAD JRY, MN 5512 | 25 | | |
| PREFIX (EACH D | MARY STATEMENT OF D EFICIENCY MUST BE PRE ORY OR LSC IDENTIFYIN | EFICIENCIES ECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE | (X5) COMPLET DATE |
| 2 895 Continued | From page 10 | | 2 895 | | | |
| and added was to com days a wee explained t about a ner nursing sta assess R12 continuing said therap that nursing walking pro | g assistant is able to that the current order tinue to walk with R ek, between 100-200 hat for a day there w wly observed walkin ff had waited for phy 28's walking for safe the walking program by had given staff ve g assistants were safe ogram as ordered, e asked R128 about g agreed. | er from therapy 128 once a day, 7 0 feet. NA-F vas a question g concern, and ysical therapy to ety before n. However, NA-F rbal confirmation afe to continue the very day. At 2:06 | | | | |
| walking in t Another sta case the re walking on around to v wheelchair NA-F said far, and wa back. NA-F care sheet R128's res daily walkin on the care | at 2:22 p.m., R128 the hall with NA-F, u aff followed R128 with sident needed to sitt e length of the hall, le valk back, but stopp for a couple minute R128 had walked at s resting before finite pulled a current nu out of a cabinet, and torative program. No torative program. No tor | sing a walker. th a wheelchair in and rest. After R128 turned ed to rest in the s. At 2:27 p.m. bout 110 feet so shing the walk rsing assistant d reviewed it for A-F confirmed the 00 feet was listed tt should happen | | | | |
| walking and When aske said walkin feeling tired | at 2:37 p.m., R128 d was resting in bed ed how the resident g felt good today. R d, and F-E stated R ⁻ k without resting. | visiting with F-E. was feeling, R128 128 acknowledged | | | | |
| | at 2:42 p.m., the dinterviewed about R1 | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED | | |
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| AME OF F | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, S | TATE, ZIP CODE | | | |
| OODBI | URY HEALTH CARE (| CENTER | AKE ROAD BURY, MN 5512 | 25 | | | |
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| 2 895 | Continued From pa | ige 11 | 2 895 | | | | |
| | were suppose to of The DT said R128 but confirmed staff addition, the DT sa when nursing staff whether it was safe he had assessed F the walking program recommended. DT was able to walk do stopping, but said F hospitalizations sin would expect to see On 4/12/18 at 3:14 confirmed that if the for walking every do walk the resident se | described a time when R128 own the hall and back withou R128 has had multiple ce January 2018, and therap e some decline due to that. p.m., registered nurse (RN)- erapy wrote a recommendati ay, then staff should offer to even days a week. | ear ed d 3 t y F on | | | | |
| | A policy regarding r was requested, but | rehabilitative nursing progran not provided. | ns | | | | |
| | The director of nurse review and revise p to ensuring the rest each individual rest could develop a syst develop a monitoring | THOD OF CORRECTION: sing (DON) or designee could policies and procedures relate torative nursing care plan for dent is followed. The DON stem to educate staff and ng system to ensure staff are irected by the written plan of pility. | ed | | | | |
| | TIME PERIOD FOI (21) days. | R CORRECTION: Twenty-on | ie | | | | |
| 2 900 | MN Rule 4658.052 Ulcers | 5 Subp. 3 Rehab - Pressure | 2 900 | | | 5/21/18 | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00803 | . , | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
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| | | | | 04/ | 04/12/2018 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| NOODBI | JRY HEALTH CARE (| 'ENTER | KE ROAD URY, MN 55 | 125 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CO | | (X5) |
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| | | | | DEFICIENCY) | | |
| 2 900 | Continued From pa | ige 12 | 2 900 | | | |
| | Subp. 3. Pressure | sores. Based on the | | | | |
| | | ident assessment, the director | | | | |
| | | must coordinate the | | | | |
| | | ursing care plan which | | | | |
| | provides that: | | | | | |
| | A a resident wh | o enters the nursing home | | | | |
| | | ores does not develop | | | | |
| | | ess the individual's clinical | | | | |
| | condition demonstr | ates, and a physician | | | | |
| | authenticates, that | they were unavoidable; and | | | | |
| | D a vaaidaatu | | | | | |
| | | ho has pressure sores y treatment and services to | | | | |
| | | revent infection, and prevent | | | | |
| | new sores from dev | | | | | |
| | | | | | | |
| | This MN Requirem | ent is not met as evidenced | | | | |
| | by: | | | | | |
| | Based on observati | ion, interview and document | | Corrected | | |
| | | ailed to ensure 1 of 3 residents | 5 | | | |
| | | risk for pressure ulcers (PU) | | | | |
| | received timely rep | ositioning. | | | | |
| | Findings include: | | | | | |
| | B103 was continua | lly observed on 4/9/18, from | | | | |
| | | n. (2 hours 42 minutes). At | | | | |
| | | as observed to be sitting in a | | | | |
| | Broda chair in the c | lining room. At 7:05 p.m., | | | | |
| | | ted to his room after the meal, | | | | |
| | | oda chair, was positioned by | | | | |
| | | by nursing assistant (NA)-B. | | | | |
| | | verified R103 had not been stated R103 appeared tired, | | | | |
| | | 3 had been up prior to the | | | | |
| | | 2:30 p.m. NA-C stated R103 | | | | |
| | | sitioned since the start of the | | | | |
| | shift. | | | | | 1 |

Minnesota Department of Health STATE FORM

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If continuation sheet 13 of 34

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | |
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| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| NOODB | URY HEALTH CARE | CENTER | KE ROAD URY, MN 5512 | 25 | | | |
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| 2 900 | Continued From pa | age 13 | 2 900 | | | | |
| | 4/10/18, from 9:03 hours 49 minutes). sitting in a wheelch observation period by staff to repositio and NA-E transferr stand (mechanical confirmed R103 wa bladder.During the R103's incontinent with a small amour with urine. R103's reddened, and the open areas noted. | observations of R103 on a.m. through 12:52 p.m. (3 R103 was observed to be nair. During the continuous , there were no attempts made on R103. At 12:52 p.m. NA-A red R103 to bed with an EZ lift). Both NA-A and NA-E as incontinent with bowel and observation at 12:52 p.m., pad was observed to be soiled to f feces, and was saturated coccyx was noted to be slightly skin appeared wrinkled with no | k | | | | |
| | 4/10/18, multiple st director, music the (RN)-C, licensed p nursing assistants and NA-E) walked | ous observation time on taff including the memory care rapist, registered nurse ractical nurse (LPN)-B and (NA-A, NA-B, NA-C, NA-D, past R103 without offering the ncluding repositioning. | | | | | |
| | not been offered to morning at approxi | 7 p.m., NA-A verified R103 had be repositioned since that mately 8:00 a.m. NA-A said why she had not repositioned | k | | | | |
| | admitted to the fac including: anxiety c disorder, mood (af | record revealed R103 was ility 6/7/17, with diagnosis disorder, major depressive fective) disorder, Parkinson's ntia with behavior disturbance. | | | | | |
| | | m Data Set (MDS) 3/14/18, indicated R103 assist of two with bed mobility | , | | | | |

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| 2 900 | Continued From pa | ige 14 | 2 900 | | | | |
| | transfers and toileting. The MDS further indicated R103 was always incontinent of bladder, and frequently incontinent of bowel. A Brief Interview for Mental Status (BIMS) score was recorded as 99 indicating the resident was unable to be assessed. | | | | | | |
| | included: " requir with all activities of | sment (CAA) dated 9/19/17, res extensive to total assist daily living (ADL's) and risk for alteration in skin (urinary tract | | | | | |
| | "Encourage reposit rounds and every 2 care plan indicated impairment to skin | ated 7/3/17, directed staff, ion/position changes during hours as able." The 11/16/17 , "[R103] has potential integrity due to impaired I poor appetite, use of nence" | | | | | |
| | | ng Assistant Assignment Sheet Q2H (reposition every two of two)" | | | | | |
| | expectation is nursi |) a.m., RN-C stated, "My ing staff need to follow re that directs nursing staff to every two hours." | | | | | |
| | director of nursing of residents at risk for they are receiving t treatment/services from developing. The designee, could con- | to prevent pressure ulcers he director of nursing or nduct random audits of the | | | | | |
| | | ensure appropriate care and nented; to reduce the risk for | | | | | |

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| 2 900 | Continued From pa | ige 15 | 2 900 | | | |
| | pressure ulcer deve | elopment. | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 920 | MN Rule 4658.052 | 5 Subp. 6 B Rehab - ADLs | 2 920 | | 5/21/18 | |
| | comprehensive res home must ensure B. a resident who activities of daily liv | is unable to carry out ing receives the necessary n good nutrition, grooming, | | | | |
| | by: Based on observati review, the facility f (R111 and R103) re | ent is not met as evidenced ion, interview and document ailed to ensure 2 of 4 residents eviewed for activities of daily ning/hygiene assistance and ontinence care. | 5 | Corrected | | |
| | Findings include: | | | | | |
| | assessment dated cognitively intact, to more staff for trans required extensive staff for personal hy | ninimum data set (MDS) 1/18/18, indicated R111 was otally dependent on two or ferring between surfaces and assistance from two or more ygiene. According to the MDS, s not having bathed during the nce period. | | | | |
| | interview she was r enough, and was u | o.m., R111 stated during not being bathed frequently nsure of her scheduled bath aff had asked her to bathe late | | | | |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
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| | | | A. BUILDING: _ | | | |
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| 2 920 | Continued From pa | age 16 | 2 920 | | | |
| 1 | | nd stated she had refused d 11 reported she felt she sho weekly. | | | | |
| | interview, R111 sta for 3 weeks. R111 under my arms" an smelled of feces. D | 5 a.m., during a follow up ated she had not been bathe stated, "I smell all the time d also stated she thought sh During the interview, R111's h bily and damp, and R111 did | he hair | | | |
| | manager (RN)-E, ro bath the previous w offered. RN-E state bath on their sched | a.m. the registered nurse/u eported R111 had refused h veek due to the late hour it v ed when a resident refused a luled weekly bath day, anoth be offered that week. | er vas a | | | |
| | | 9 p.m., R111 was observed nair matted to her head. | | | | |
| | no direction related undated nursing as R111 required assis and bed mobility, a transferring with a f | st revised on 2/5/18, include I to bathing assistance. R11 sistant care plan, indicated stance of 2 staff for bathing nd 2 staff assistance with full mechanical lift. The care R111 was scheduled to be afternoons. | 1's | | | |
| | revealed R111 was assistance during t On 4/2/18 and 4/9/ indicated R111 had | ing record was reviewed an totally dependent on staff for pathing on 3/19 and 3/26/18. 18, the documentation I refused a bath during the other bathing opportunities as offered. | or | | | |
| | R111's Progress No | otes dated 3/1 to 4/12/18, | | | | |

| STATEMEN | <u>ta Department of He</u> TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: _ | CONSTRUCTION | СОМ | E SURVEY PLETED |
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| 2 920 | Continued From pa | age 17 | 2 920 | | | |
| | provided no further refusals or opportu | information related to bathing nities. | | | | |
| | revised 4/26/17, dir scheduled. Weekly bath or shower. Th hairs (men or those shop). Use of deod dry skin areas. Nail more often as need provided by the lice resident's care plar tub bath." | ards of Care Guidelines last rected staff: "Bath/showers as minimum of complete tub is includes body, nails, ears, women not going to beauty lorant to underarm. Lotion to ls are to be trimmed weekly or ded. (Diabetic nail care is to be ensed staff). Bed bath per n if unable to tolerate shower or | | | | |
| | 4:41 p.m 7:23 p.m 4:41 p.m., R103 wa Broda chair in the o R103 was transpor and R103 in the Bro the foot of the bed At 7:21 p.m., NA-C checked for inconti appeared tired, and prior to the start of stated R103 had no | Illy observed on 4/9/18, from n. (2 hours 42 minutes). At as observed to be sitting in a dining room. At 7:05 p.m., ted to his room after the meal, oda chair, was positioned by by nursing assistant (NA)-B. verified R103 had not been nence. NA-C stated R103 d confirmed R103 had been up his shift at 2:30 p.m. NA-C ot been checked for the start of the shift. | | | | |
| | 4/10/18, from 9:03 hours 49 minutes). sitting in a wheelch observation period, by staff to check R ² p.m. NA-A and NA- an EZ stand (mech NA-E confirmed R ¹ and bladder. During | observations of R103 on a.m. through 12:52 p.m. (3 R103 was observed to be air. During the continuous there were no attempts made 103 for incontinence. At 12:52 E transferred R103 to bed with anical lift). Both NA-A and 103 was incontinent of bowel g the observation at 12:52 tinent pad was observed to be | | | | |

Minnesota Department of Health STATE FORM

6899

QPXY11

If continuation sheet 18 of 34

| STATEMEN | Dta Department of He NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | |
|--------------------------|--|--|--------------------------|---|--------------------------------|-------------------------|--|
| | | 00803 | B. WING | B. WING | | C 04/12/2018 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, S | TATE, ZIP CODE | | | |
| VOODB | URY HEALTH CARE | CENTER | KE ROAD BURY, MN 5512 | 25 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE | |
| 2 920 | Continued From pa | age 18 | 2 920 | | | | |
| | soiled with a small saturated with urine | amount of feces, and was e. | | | | | |
| | 4/10/18, multiple st director, music the (RN)-C, licensed pl nursing assistants | bus observation time on aff including the memory care rapist, registered nurse ractical nurse (LPN)-B and (NA-A, NA-B, NA-C, NA-D, past R103 without offering the | | | | | |
| | | 7 p.m., NA-A verified R103 ha for incontinence since that mately 8:00 a.m. | d | | | | |
| | admitted to the fact including: anxiety d disorder, mood (aff | record revealed R103 was ility 6/7/17, with diagnosis lisorder, major depressive fective) disorder, Parkinson's ntia with behavior disturbance | | | | | |
| | required extensive transfers and toilet R103 was always in frequently incontine for Mental Status (I | m Data Set (MDS) 3/14/18, indicated R103 assist of two with bed mobility ing. The MDS further indicated ncontinent of bladder, and ent of bowel. A Brief Interview BIMS) score was recorded as esident was unable to be | b | | | | |
| | included: " require with all activities of | sment (CAA) dated 9/19/17, res extensive to total assist daily living (ADL's) and risk for alteration in skin (urinary tract | | | | | |
| | | ated 7/3/17, directed staff, two for check and change | | | | | |

STATE FORM

QPXY11

If continuation sheet 19 of 34

| Minneso | ta Department of He | alth | | | | APPROVED |
|--------------------------|---|---|------------------------|---|--------------------------------|--------------------------|
| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | E SURVEY PLETED |
| | | | / | | С | |
| | | 00803 | B. WING | | 04/ | 12/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE O | ENTER | KE ROAD URY, MN 551 | 25 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 2 920 | Continued From pa | ge 19 | 2 920 | | | |
| | and during night rou | and after meals, a bedtime unds" The undated Nursing ent Sheet included the same | | | | |
| | expectation is nursi | a.m., RN-C stated, "My ng staff need to follow e that directs nursing staff." | | | | |
| | Evaluation dated 20 each resident's con appropriate treatme assist residents in r highest practicable | | | | | |
| | director of nursing (review and revise p to ensuring residen ADLs receive timely needs. The DON of on policies and pro- designee could auc | HOD OF CORRECTION: The DON) or designee could olicies and procedures related ts who require assistance with assistance to meet their designee could educate staff cedures. The DON or lit to ensure compliance and he quality assurance | | | | |
| | TIME PERIOD FOF (21) days. | R CORRECTION: Twenty-one | | | | |
| 21015 | MN Rule 4658.0610 Requirements- Sai |) Subp. 7 Dietary Staff nitary conditi | 21015 | | | 5/21/18 |
| | | conditions. Sanitary nditions must be maintained in | | | | |
| linnesota De | epartment of Health VI | | 6899 | PXY11 | | |

| | ta Department of He TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00803 | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 04/12/2018 | |
|--------------------------|--|--|---------------------|--|--|-------------------------|
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS. CITY. | STATE, ZIP CODE | | |
| | | 7012 4 | KE ROAD | | | |
| WOODB | URY HEALTH CARE C | - ENTER | URY, MN 55 | 125 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLET DATE |
| 21015 | Continued From pa | ge 20 | 21015 | | | |
| | the operation of the times. | dietary department at all | | | | |
| | by: Based on observati review, the facility fa dried prior to storing supplements were the potential to imp | ent is not met as evidenced on, interview and document ailed to ensure dishes were ai g, and failed to ensure dated when thawed. This had act all six residents residing or 10 residents who received tents. | | Corrected | | |
| | Findings include: | | | | | |
| | kitchenettes were to (DA)-A and DA-B w from the clean side putting them in stor the plate holder, pu in the drawers, stac of dry racks of cups metal carts and star At that time, the die this finding, noting of DM stated dishes w and added she'd pu the dishwasher to e verified she was tra dry. The DM stated were for the resider who received room refrigerators reveale supplements thave orange supplement and 3rd floor: 2 prot | p.m. the kitchen and unit bured. Two dietary aides ere observed grabbing dishes of the dish machine and age wet, stacking plates wet in tting wet scoops and utensils sking racks of wet cups on top s, stacking wet bowls in the cking wet trays in floor carts. tary manager (DM) confirmed drops of water on dishes. The vere supposed to be air dried, urchased a special product for onsure quick drying. DA-B ined to put the dishes away the dishes being stacked wet nts residing on the lower level trays. A tour of the unit ed: 1st floor: 5 orange d and undated, 2nd floor: 4 s stored thawed and undated, tein shakes stored thawed and to directions on the | n | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|-------------------|---|--|---|--|-------------------------------|-----------------|--|
| | | | A. BUILDING. | | С | | |
| | | 00803 | B. WING | | | 04/12/2018 | |
| IAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| VOODB | URY HEALTH CARE | CENTER | KE ROAD URY, MN 5512 | 25 | | | |
| (X4) ID PREFIX | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT | ION SHOULD BE | (X5) COMPLET | |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO T DEFICIENC | | DATE | |
| 21015 | Continued From pa | age 21 | 21015 | | | | |
| | | than 14 days after thawed. the supplements should have aken out to thaw. | | | | | |
| | | nachine Policy dated 6/15/17, Il items. Do not stack or nest | | | | | |
| | included: "Each lab information: produc or identifying descr product was prepa and team member | Labeling policy dated 6/15/17, bel must contain the following ct name (or a common name ription), use by date, date the red or opened, time prepared initials where applicable, date e, and date thawed, if | | | | | |
| | The dietary manag and revise, as need for washing, drying labeling of foods we manager or design these policies and The dietary manag | THOD OF CORRECTION: ler or designee could review ded policies and procedures and storing dishes, and hen opened. The dietary lee could educate staff on audit to ensure compliance. ler could report progress and quality assurance committee. | | | | | |
| | TIME PERIOD FO (21) days. | R CORRECTION: Twenty-one | | | | | |
| 21375 | MN Rule 4658.080 Program | 0 Subp. 1 Infection Control; | 21375 | | | 5/21/18 | |
| | home must establi | on control program. A nursing sh and maintain an infection esigned to provide a safe and ent. | | | | | |

| | ta Department of He TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 04/12/2018 | |
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| | | 00803 | B. WING | | | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, | STATE, ZIP CODE | | |
| NOODB | URY HEALTH CARE (| IENTER | KE ROAD URY, MN 55 [.] | 25 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECT | | (X5) |
| PRÉFIX TAG | | YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | COMPLET DATE |
| 21375 | Continued From pa | ge 22 | 21375 | | | |
| | by: | ent is not met as evidenced | | | | |
| | review, the facility fa spead of infection r cleansing of a blood | on, interview and document ailed to minimize the risk for elated to the handling and d glucose meter (device used s) for 1 of 1 (R118) resident | | Corrected | | |
| | Findings include: | | | | | |
| | (LPN)-A was observing wiped R118's finger R118's finger with a drop of blood with a glucometer to deter LPN-A then put the plastic container of LPN-wrapped a sar glucometer and let minutes, however, the ends of the glucom the test strip was in glucometer for about the glucometer out request and confirm acknowledged the glucometer of the glucometer of the glucometer out request and confirm acknowledged the glucometer of the glucometer other the gl | p.m., licensed practical nurse ved to wear gloves when she with an alcohol wipe, poked a single use lancet, obtained a a test strip she inserted into the mine blood sugar results. used glucometer on top of the single use unused lancets. hitizing wipe around the it rest on the cart for several the wrap did not cover the eter, including the end where serted. LPN-A wiped the ut 10 seconds and put it in mediately after, LPN-A took of the medication cart upon hed it was not still wet. LPN-A glucometer was on the lancets not good." LPN-A then said the to be disposed. | | | | |
| | nursing and registe dirty glucometer sho clean lancets and the thoroughly cleaned. | p.m. the assistant director of red nurse (RN)-F, reported a ould not be placed on top of ne glucometer should be . RN-F confirmed the used for multiple patients. | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ B. WING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 04/12/2018 | |
|--------------------------|--|---|--|---|--|-------------------------|
| | | 00803 | | | 04/ | 12/2018 |
| | PROVIDER OR SUPPLIER | 7012 4 | DDRESS, CITY, ST KE ROAD | ATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE (| :ENTER | URY, MN 5512 | 5 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 21375 | Continued From pa | ge 23 | 21375 | | | |
| | revised 9/2017, inc Use a Sani-Cloth S from container. b) T meter c) If wipe is w excess so as not to code ports during c keeping the glucom Sani-Wipe is 2 min glucometer remains down for two full mi wipe after thorough full minutes place the allow the glucometer hygiene." | s moist, either wipe meter inutes or wrap the meter in the Iy wiping it down. e) After two ne meter on a clean surface to er to dry. f) Perform hand | | | | |
| | The infection prevereview and revise p glucometers. The in educate all staff and compliance. The in report results of auto committee. | HOD OF CORRECTION: ntionist or designee could policies related to cleaning nfection preventionist could d perform audits to ensure fection preventionist could dits to the quality assurance R CORRECTION: Twenty-one | | | | |
| 21426 | Prevention And Con (a) A nursing home maintain a comprel infection control pro current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin | A.04 Subd. 3 Tuberculosis ntrol e provider must establish and nensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). | 21426 | | | 5/21/18 |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 00803 | B. WING | B. WING | | C 04/12/2018 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | | |
| NOODB | URY HEALTH CARE | CENTER | KE ROAD URY, MN 55 | 125 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLET DATE | |
| 21426 | Continued From pa | age 24 | 21426 | | | | |
| | infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme | t include a tuberculosis an that covers all paid and , contractors, students, inteers. The Department of e technical assistance intation of the guidelines. ance with this subdivision mus he nursing home. | t | | | | |
| | by: Based on documer facility failed to ens (TB) screening acc Minnesota Departn guidelines, Regula in Minnesota Healt | tent is not met as evidenced int review and interview, the sure appropriate tuberculosis cording to facility policy and the nent of Health (MDH) tions for Tuberculosis Control h Care Settings, was 5 residents (R117, R128, R45, B screening. | | Corrected | | | |
| | Tuberculosis Contr Settings (version J baseline TB screer homes consists of for current symptor assessing for TB ri testing for the pres | I guideline Regulations for rol in Minnesota Health Care uly 2013) revealed that the ning of residents in nursing three components: assessing ms of active TB disease, isk factors and TB history, and ence of infection by er a two-step TST (tuberculin blood test. | | | | | |

| Minneso | ota Department of He | alth | | | FORM | APPROVED |
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| STATEME | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
| | | 00803 | B. WING | | | C 12/2018 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | TATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE (| CENTER 7012 LAP | KE ROAD JRY, MN 5512 | 25 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CO | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | | COMPLETE DATE |
| 21426 | Continued From pa | ige 25 | 21426 | | | |
| | guideline, in that it it screening to be initial admission or within and to include an a TB, and any current two-step TST or a set the policy required TST should received residents who refuses should have a chest TB disease. To doc facility policy required administration, the induration, and inte or negative). Review of resident electronic medical if following: R117 was admitted refused to order the documentation of a provided. R128 was admitted not initiated within 7 first step TST was g screen, using the T 1/7/18. R45 was admitted or second step TST or sec | consistent with the MDH required the resident TB iated within 72 hours of 90 days prior to admission, ssessment of risk factors for t TB symptoms, and a single blood test. Additionally, that residents who refuse the e a single blood test, and se both the TST and blood test st x-ray to rule out infectious sument skin test results, the ed staff to record the date of number of millimeters of rpretation of results (positive TB screening records in the record (eMR) revealed the con 3/8/18. R117's provider e two step TST on 3/8/18. No blood test or chest x-ray was I on 8/29/17. Screening was 72 hours of admission. The given 9/7/17. The TB symptom B Screening Tool, was dated on 10/28/17, but no symptom ing Tool) was provided. n 9/15/17, and received a n 9/24/17, but the nillimeters of induration were | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED | |
|---------------|---|---|------------------------------|---|----------------|--------------------|--|
| | | | A. BUILDING. | | С | | |
| | | 00803 | B. WING | | | 04/12/2018 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | STATE, ZIP CODE | | | |
| NOODB | URY HEALTH CARE | CENTER | KE ROAD URY, MN 551 | 25 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF (| | (X5) | |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLET DATE | |
| 21426 | Continued From pa | age 26 | 21426 | | | | |
| | registered nurse (F the TB testing show record under the in confirmed that a TS documented interp induration would be to find an earlier TF | n 4/12/18 at 3:45 p.m., RN)-F said documentation for uld be in the electronic medica nmunizations' tab. RN-F ST reading without retation and millimeters of e incorrect. RN-F was unable B symptom screen for R128, find the TB screening tool at a | | | | | |
| | The director of nur review and/or revis procedures to ensu- for TB within the ap admission, and sta proper documenta The DON or design appropriate staff or DON or designee of system to ensure of | THOD OF CORRECTION: sing (DON) or designee could be the current TB policies and ure all residents are screened opropriate timeframes upon off complete and maintain tion of the screening process. The could educate the in the policies/procedures. The could develop a monitoring ongoing compliance. R CORRECTION: Twenty-one | | | | | |
| 21620 | | 5 Labeling of Drugs | 21620 | | | 5/21/18 | |
| | Drugs used in the in accordance with | nursing home must be labeled part 6800.6300. | | | | | |
| | by: Based on observat review, the facility t | ent is not met as evidenced ion, interview and document failed to ensure medications beled properly for 5 of 14 | | Corrected | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: _ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
|---------------|---|---|-------------------------|---|------------------------------------|-----------------|
| | | 00803 | B. WING | | 04/ | 12/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, S | TATE, ZIP CODE | | |
| WOODB | URY HEALTH CARE (| :ENTER | KE ROAD URY, MN 5512 | 25 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | ORRECTION | (X5) |
| PRÉFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY) | E APPROPRIATE | COMPLET DATE |
| 21620 | Continued From pa | ige 27 | 21620 | | | |
| | residents (R80, R1) reviewed for medic | 2, R67, R58 and R118) ation storage. | | | | |
| | Findings include: | | | | | |
| | storage areas throu for R80, R12, R67, Inhalers and Insulir dates to indicate wi when the medication insulin flexpen was During a medication 4/11/18 at 10:24 a.r nurse (LPN)-A, the treatment cart was expired insulin avai treatment cart: R80's Novolog insu opened on 2/24/18, was identified as op | n pen was undated as to wher | 3 | | | |
| | Aerosol inhaler for but not dated as to At 10:41 a.m., LPN be labeled and stor would remove the i new inhaler from th During observation of the medication s | 11/18, an Advair Diskus R67 was observed to be open when it had been put into use. I-A verified medications should ed properly. LPN-A stated she nhaler and replace it with a e medication storage room. s with registered nurse (RN)-A torage cart on the transitional the first floor, on 4/11/18 at | ł | | | |
| | 10:44 a.m., two Adv R58 were observed were undated as to | vair Diskus Aerosol inhalers fo to be opened for use, but when opened. At 10:47 a.m., cations should be labeled and | r | | | |

| | ta Department of He T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | | - | | С | |
| | | 00803 | B. WING | | 04/ | 12/2018 |
| IAME OF I | PROVIDER OR SUPPLIER | STREET # | ADDRESS, CITY, S | TATE, ZIP CODE | | |
| VOODB | URY HEALTH CARE (| CENTER | AKE ROAD BURY, MN 5512 | 25 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| 21620 | Continued From pa | age 28 | 21620 | | | |
| | | d stated she would remove the om the medication cart and of nursing (DON). | 9 | | | |
| | TCU cart on 4/11/1 insulin flexpen was was dated 3/8/18. on the insulin pen. Novolog flexpen, bu lacked an appropria would remove the i | s with RN-B of the lower level 8 at 11:07 a.m., a Novolog observed to be opened, and However, there was no label RN-B stated it was R118's ut verified the insulin pen ate label. RN-B stated she nsulin pen from use and her insulin flex pen from the efrigerator. | | | | |
| | p.m., the DON state about the medication addressed, and sho use as necessary, replacements. In an soon as replacement | th the DON on 4/11/18 at 1:07 ed she would ensure concern ons identified would e would pull medications from contact the pharmacy and get ddition, the DON stated as ent medications arrived, she'd uppropriately labeled before rculation. | s | | | |
| | MEDICATION date "Outdated, contam medications, and th cracked, soiled, or immediately remov according to proce | and procedure STORAGE Of ad April 2014, included: inated or deteriorated nose in containers that are without secure closures, are ed from stock, disposed of dures for medication disposal in the pharmacy, if a current | | | | |
| | LABELS dated Jun no circumstances a requested or accept | and procedure MEDICATION e 2015, included:"G. Under are unattached labels oted from the pharmacy. Only place a label on the | r | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00803 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | | E SURVEY PLETED C 12/2018 |
|--------------------------|---|---|---------------------|--|--------------------------------|------------------------------------|
| | PROVIDER OR SUPPLIER | | ADDRESS, CITY, ST | | | 12/2010 |
| | URY HEALTH CARE (| 7012 | AKE ROAD | | | |
| | | WOOD | BURY, MN 5512 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLET DATE |
| 21620 | Continued From pa | ige 29 | 21620 | | | |
| | having soiled, dama confusing, or make the medication sup accordance with the policy. If the medica supply is ordered fr SUGGESTED MET administrator, direc consulting pharmac policies and proced medications. Nursin necessary to the im medications proper medications. The D | THOD OF CORRECTION: The tor of nursing (DON) and cist could review and revise dures for proper storage of ng staff could be educated as uportance of labeling dy and discarding expired DON or designee, along with uld audit medications on a | ll | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-on | e | | | |
| 21830 | MN St. Statute 144 Residents of HC Fa | .651 Subd. 10 Patients & ac.Bill of Rights | 21830 | | | 5/21/18 |
| | Subd. 10. Particip notification of family | pation in planning treatment; y members. | | | | |
| | in the planning of the includes the opport alternatives with inco- opportunity to reque- care conferences, a family member or of both. In the event to present, a family m | Il have the right to participate heir health care. This right unity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a other chosen representative of that the resident cannot be ember or other representative dent may be included in such | or e | | | |

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVI COMPLETED C | |
|---------------|---|---|---|--|-----------------------------------|-----------------|
| 00803 | | 00803 | B. WING | | | 12/2018 |
| AME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| NOODB | URY HEALTH CARE (| :ENTER | KE ROAD URY, MN 5512 | 25 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | | (X5) |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLET DATE |
| 21830 | Continued From pa | ge 30 | 21830 | | | |
| | (b) If a resident v | vho enters a facility is | | | | |
| | | natose or is unable to | | | | |
| | communicate, the f | acility shall make reasonable | | | | |
| | | under paragraph (c) to notify | | | | |
| | either a family member or a person designated in | | | | | |
| | | writing by the resident as the person to contact in | | | | |
| | an emergency that the resident has been admitted to the facility. The facility shall allow the | | | | | |
| | | | | | | |
| | family member to participate in treatment planning, unless the facility knows or has reason | | | | | |
| | to believe the resident has an effective advance | | | | | |
| | directive to the contrary or knows the resident has | | | | | |
| | specified in writing that they do not want a family | | | | | |
| | member included in treatment planning. After | | | | | |
| | | ember but prior to allowing a | | | | |
| | | articipate in treatment | | | | |
| | | / must make reasonable | | | | |
| | | vith reasonable medical | | | | |
| | | ne if the resident has | | | | |
| | | ce directive relative to the | | | | |
| | this paragraph, "rea | e decisions. For purposes of asonable efforts" include: e personal effects of the | | | | |
| | resident; | | | | | |
| | | e medical records of the | | | | |
| | | session of the facility; | | | | |
| | | ny emergency contact or | | | | |
| | | family member contacted under this section | | | | |
| | | nt has executed an advance | | | | |
| | | er the resident has a | | | | |
| | care; and | the resident normally goes for | | | | |
| | | e physician to whom the | | | | |
| | | oes for care, if known, | | | | |
| | | nt has executed an advance | | | | |
| | | y notifies a family member or | | | | |
| | | ncy contact or allows a family | | | | |
| | member to participa | ate in treatment planning in | | | | |
| | | s paragraph, the facility is not | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED C | | |
|---|---|---|-----------------------|---|--|----------------|
| | | 00803 | B. WING | | | 12/2018 |
| AME OF I | PROVIDER OR SUPPLIER | | | TATE, ZIP CODE | | |
| VOODB | URY HEALTH CARE | CENTER 7012 LAK WOODBU | E ROAD RY, MN 5512 | 25 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CO | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | | COMPLE DATE |
| 21830 | Continued From pa | age 31 | 21830 | | | |
| | the notification of the emergency contact family member was patient's privacy rig (c) In making rea- family member or of the facility shall atter members or a desi examining the pers and the medical re possession of the faci- to notify a family memergency contact admission, the faci- social service ager agency that the res- the facility has bee member or designa- county social service enforcement agendidentifying and noti- designated emerges service agency or I that assists a faciliti subdivision is not I damages on the gr the family member participation of the or violated the patier This MN Requirem by: Based on interview facility failed to ensi- | asonable efforts to notify a designated emergency contact, empt to identify family gnated emergency contact by sonal effects of the resident cords of the resident in the facility. If the facility is unable ember or designated t within 24 hours after the lity shall notify the county ney or local law enforcement sident has been admitted and n unable to notify a family ated emergency contact. The ce agency and local law cy shall assist the facility in fying a family member or ency contact. A county social ocal law enforcement agency ty in implementing this able to the resident for rounds that the notification of or emergency contact or the family member was improper ent's privacy rights. | | Corrected | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00803 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | | (X3) DATE SURVEY COMPLETED C 04/12/2018 | |
|---|---|---|---|--|--|-------------------------|
| | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | | 04/ | 12/2010 |
| | | 7012 4 | KE ROAD | | | |
| VOODB | URY HEALTH CARE (| CENTER | URY, MN 5512 | 5 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21830 | Continued From pa | age 32 | 21830 | | | |
| | Findings include: | | | | | |
| | according to the mi assessment dated cognitively impaired status score of 5). alongside a family interview on 4/9/18 about the ability for were important to t about bathing choic offered a choice of when R128 was ac resident all residen shower day. F-E sa extra shower, as al weekly shower. Wh preferences, F-E sa or more showers e | d to the facility on 8/29/17, and inimum data set (MDS) 3/19/18, was assessed to be d (brief interview for mental R128 was interviewed member (F)-E. During , at 6:22 p.m., F-E was asked r R128 to make choices that he resident. When asked ces, F-E said R128 was not bathing frequency. F-E said mitted, staff informed the ts had an assigned weekly aid R128 was not offered an Il residents had an assigned hen asked about R128's past aid that R128 used to take two ach week. F-E expressed a be able to have at least two hile at the facility. | | | | |
| | Daily and Activity P revealed a section Preferences. Accor resident was asked how important is it tub bath, shower, b R128's response w | ty's assessment, Interview for Preferences dated 9/1/17, titled, Interview for Daily rding to the assessment, the d, "While you are in this facility to you to choose between a bed bath, or sponge bath?" vas documented as, "Very sessment did not include a quency of bathing. | | | | |
| | licensed practical r about the process bathing preference completed initial ac | n 4/12/18, at 2:11 p.m., hurse (LPN)-C was asked for assessing residents' s. LPN-C said the nurses dmission assessments for idents. LPN-C was unsure | | | | |

| STATEME | ota Department of He NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---------------|---|---|----------------------------|---|-------------------------------|-----------------|
| | | IDENTITION TON NOMBER. | A. BUILDING: | | | |
| | | 00803 | | | | C 12/2018 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| NOODB | | CENTER | KE ROAD URY, MN 5512 | 25 | | |
| (X4) ID | | | ID | | | (X5) COMPLET |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | DATE |
| 21830 | Continued From pa | age 33 | 21830 | | | |
| | the residents' prefet bathing. LPN-C ver day was based on and said if someon another shower, sti- but explained that if assigned initially by ensure care staff winumber of showers During interview or registered nurse (Fi process for assignion on a resident's root acknowledged assishower schedule bild did not seem to be A policy regarding a preferences was residents' choices and residents' choices and residents' choices and residents' choices and residents' choices and residents' choices and residents' choices and are honored. The Di educate all approping procedures and co systems to ensure | sion assessment asked about erences for frequency of erified each resident's shower the resident's room number ne specifically requested aff would accommodate that, the shower schedule was y room number in order to yere not overwhelmed by the s to be completed in a day. A 4/12/18, at 2:56 p.m., RN)-F was asked about the ing one shower a week based m number. RN-F igning residents a weekly ased solely on room number very individualized. assessment of bathing equested but not provided. THOD OF CORRECTION: sing (DON) or designee could nd procedures to ensure regarding care and routines DON or designee could riate staff on these policies and uld develop monitoring ongoing compliance. R CORRECTION: Twenty-one | | | | |