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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QPXY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00803

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245235**
2.STATE VENDOR OR MEDICAID NO.
(L2) **662675000**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODBURY HEALTH CARE CENTER**
(L4) **7012 LAKE ROAD**
(L5) **WOODBURY, MN** (L6) **55125**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/01/2007**

6. DATE OF SURVEY **05/24/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **165** (L18)
13.Total Certified Beds **165** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	165			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Eva Loch, Unit Supervisor 05/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/26/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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,

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

cc: Licensing and Certification File

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,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QPXY

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Facility ID: 00803

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(L1) **245235**
2.STATE VENDOR OR MEDICAID NO.
(L2) **662675000**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODBURY HEALTH CARE CENTER**
(L4) **7012 LAKE ROAD**
(L5) **WOODBURY, MN** (L6) **55125**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/01/2007**

6. DATE OF SURVEY **04/12/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

12.Total Facility Beds **165** (L18)
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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	165			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Sheryl Reed, HFE NE II 05/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/25/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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06/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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: 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, H5235088, and 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:

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

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

Remedies - 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;

Potential Consequences - 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements was conducted on 4/9 through 4/12, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted April 9th through April 12, 2018. Complaint investigations were also completed at the time of the standard survey, H5235086, H5235088, H5235089 and H5235090 were investigated and found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		5/21/18

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

Electronically Signed | 05/04/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R128) reviewed for choices had the opportunity to bathe more than once a week. Findings include: R128 was admitted to the facility on 8/29/17, and according to the minimum data set (MDS) assessment dated 3/19/18, was assessed to be cognitively impaired (brief interview for mental status score of 5). R128 was interviewed alongside a family member (F)-E. During interview on 4/9/18, at 6:22 p.m., F-E was asked about the ability for R128 to make choices that	F 561	This plan and response to these survey findings are written solely to maintain certification in the Medicare and Medicaid programs. These written responses do not constitute an admission of noncompliance with any requirement nor an agreement with any findings. We wish to preserve our rights to dispute these findings in their entirety at anytime and in any legal action. It is the policy of Woodbury Health Care Center (WHCC) to promote and facilitate resident self determination through support of resident choice, including but	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, MN 55125**

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F 561	Continued From page 2 were important to the resident. When asked about bathing choices, F-E said R128 was not offered a choice of bathing frequency. F-E said when R128 was admitted, staff informed the resident all residents had an assigned weekly shower day. F-E said R128 was not offered an extra shower, as all residents had an assigned weekly shower. When asked about R128's past preferences, F-E said that R128 used to take two or more showers each week. F-E expressed a desire for R128 to be able to have at least two showers a week while at the facility. Review of the facility's assessment, Interview for Daily and Activity Preferences dated 9/1/17, revealed a section titled, Interview for Daily Preferences. According to the assessment, the resident was asked, "While you are in this facility how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?" R128's response was documented as, "Very Important." The assessment did not include a question about frequency of bathing. During interview on 4/12/18, at 2:11 p.m., licensed practical nurse (LPN)-C was asked about the process for assessing residents' bathing preferences. LPN-C said the nurses completed initial admission assessments for newly admitted residents. LPN-C was unsure whether the admission assessment asked about the residents' preferences for frequency of bathing. LPN-C verified each resident's shower day was based on the resident's room number and said if someone specifically requested another shower, staff would accommodate that, but explained that the shower schedule was assigned initially by room number in order to ensure care staff were not overwhelmed by the	F 561	not limited to the right to choose activities, schedules and health care consistent with his/her interests, assessments and plan of care. Plan of correction for residents cited with this survey: R128 was interviewed by the RN Manager 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 staff. Plan to address/prevent this deficiency for other residents: A 72 hour team based admission conference will be held for all admissions. Bathing preferences will be discussed with the resident and/or their representative at the meeting. Preferences will be further expanded upon during the Community Life (CL) interview for daily preferences assessment. Existing residents will be re-assessed for their bathing preference at the time of their next scheduled RAI/MDS assessment using the CL interview for daily preferences assessment. The residents□ plan of care will be updated with the preferences, as needed. Care plan changes are communicated to the staff as changes are made. Measures put in place to prevent recurrence: Audits of the 72 hour team based admission conference assessment and	

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F 561	Continued From page 3 number of showers to be completed in a day. During interview on 4/12/18, at 2:56 p.m., registered nurse (RN)-F was asked about the process for assigning one shower a week based on a resident's room number. RN-F acknowledged assigning residents a weekly shower schedule based solely on room number did not seem to be very individualized. A policy regarding assessment of bathing preferences was requested but not provided.	F 561	the CL interview for daily preferences assessment will be conducted by the LSW Director or designee and CL Director or designee for 25% of the newly admitted residents weekly x 3 months to ensure, promote and facilitate resident self-determination. A new CL interview for daily preferences assessment will be conducted for all long term residents during their next scheduled RAI/MDS assessment to ensure their preferences are known and honored. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Plan to Monitor: Audits of the 72 hour team based admission conference assessment and the CL interview for daily preferences assessment will be conducted by the LSW Director or designee and CL Director or designee for 25% of the newly admitted residents weekly x 3 months to ensure the residents preferences were documented during the interviews/conference and assessment, to promote and facilitate resident self-determination. A new CL interview for daily preferences assessment will be conducted for all long term residents during their next scheduled RAI/MDS assessment to ensure their preferences are known and honored. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Responsible for maintaining compliance: LSW Director or designee/Community Life Director or designee/ RN Manager or	

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F 561	Continued From page 4	F 561	Designee	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents (R123) reviewed for falls. Findings include: R123's Admission Record indicated R123 had diagnoses including Alzheimer's disease, anxiety disorder, major depression, legal blindness, diabetes mellitus and repeated falls. R123's annual MDS dated 3/21/18, failed to accurately reflect falls with or without minor/major injury. The 3/21/18 MDS was coded to indicate R123 had experienced one fall with no injury, two or more falls with minor injury and two or more falls with major injury from falls since admission or prior assessment, whichever was more recently related to a fall. R123's progress note dated 1/6/18, at 4:34 p.m., included: "... Resident found laying [lying] on right side in her bathroom. 1.5 cm (centimeters) X 0.2 cm laceration to right occipital area. Bleeding controlled. Dressed with gauze and stretch kerlex.. Control bleeding and initiate long neuro checks and vitals. NARs (nursing assistant registered) instructed to complete frequent visual	F 641	It is the policy of WHCC that assessments must accurately reflect the resident□s status. Plan of correction for residents cited with this survey: R123□s annual MDS assessment dated 3/21/18 has been modified and submitted to accurately reflect falls. Plan to address/prevent this deficiency for other residents: The MDS Nurses were re-educated on verifying all data that is auto-filled electronically from a previous assessment and on the correct encoding of falls to ensure accuracy. The falls log will be cross referenced by the MDS Nurse with their monthly RAI/MDS schedule to ensure all falls are captured. The MDS Nurses audited residents that fell the last quarter to ensure encoding of falls was correct. Measures put in place to prevent recurrence: The MDS Nurses were re-educated on verifying all data that is auto-filled electronically from a previous assessment and on the correct encoding of falls to	5/21/18

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F 641	Continued From page 5 monitoring on resident through the remainder of the evening shift..." R123's progress note dated 1/14/18, at 6:26 a.m., included: "Resident found on the floor during last hourly rounds. Resident was lying on her left side in her room next to her bed. No injuries noted, denies hitting head and denies pain..." R123's progress note dated 1/20/18, at 9:58 p.m., included: "At 20:04 (8:04 p.m.) resident was found on the floor in her room near the commode, face down. L (left) eye and surrounding swollen ... Ice pack on L eye ..." An incident report for R123 dated 2/22/18, included: "Resident was found on her bathroom floor with her pants half down. Resident denies hitting head, denies pain." On 4/12/18, at 12:47 p.m. registered nurse (RN)-D verified after reviewing the medical record that the annual MDS assessment dated 3/21/18, had not been coded accurately to reflect R123's falls. RN-D stated the facility would modify the MDS because R123 had experienced two falls without injuries, two falls with minor injuries and no falls with major injuries. RN-D indicated the major injury section had been auto filled from a previous MDS. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated October 2017, "... Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall ... Determine the number of falls that occurred since admission/entry or reentry or prior	F 641	ensure accuracy. The falls log will be cross referenced by the MDS Nurse with their monthly RAI/MDS schedule to ensure all falls are captured. Plan to monitor: The MDS Nurses will conduct an audit by each picking 3-4 residents RAI/MDS assessments from another floor each month, cross referencing the fall log and comparing the encoding of falls x 3 months to ensure accuracy and compliance. Audit findings will be reviewed at monthly QAPI meetings with audits continuing as warranted. Responsible for maintaining compliance: MDS Nurses/DON or designee	

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F 641	Continued From page 6 assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury..."	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		5/21/18

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F 656	Continued From page 7 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to address the use of an anticoagulant with bruising for 1 of 1 resident (R58) in the sample. Findings include: On 4/10/18 at 9:43 a.m., R58 stated during interview she had bruises on her right lower arm from hitting the grab bar, and bruises on her upper thighs. R58 pointed to her right upper arm and small dark colored spots were observed. On 4/12/18 at 9:58 a.m., R58 was observed resting in bed, covered with blankets. Her breakfast tray was on the tray table in front of her when a staff nurse brought in her medications. R58 was complaining of leg discomfort and the staff nurse removed the blanket to assess R58's leg. R58's upper right leg was observed to have several small discolored areas, less that 1 cm in size on the leg. R58's right forearm was also noted to have a scattering of small discolored marks. R58's admission record indicated she'd been admitted to the facility on 7/29/17. The admission	F 656	It is the policy of WHCC to develop and implement a comprehensive person-centered care plan for each resident. Plan of correction for residents cited with this survey: An immediate investigation was conducted to rule out maltreatment in regards to R58□s bruises and submitted to MDH 4/10/18 Incident Tracking #312437. No maltreatment was suspected. R58 was experiencing an increase in hallucinations, at which time; R58 thrashes about in bed and wheelchair. R58 bruises easily due to daily anticoagulant therapy. R58 has a history of persistent visual, auditory and tactile hallucinations. R58□s care plan has been updated to reflect increased potential for bruising /bleeding as related to the daily anticoagulant use. Plan to address/prevent this deficiency for other residents: All residents on anticoagulant therapy had their care plans reviewed and updated as	

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F 656	Continued From page 8 minimum data set (MDS) assessment dated 8/5/17, indicated R58 's cognition was intact with a BIMS (brief interview for mental status) score of 14, indicating cognition was good. The MDS further indicated R58 had no behavioral concerns and indicated R58 was on an anticoagulant. A review of physician orders indicated R58 had an order for eliquis (a blood thinner) to be administered orally every day. The care plan, last updated on 9/15/17, indicated R58 had diagnoses that included hypertension, history of cerebral infarction, and atrial fibrillation. The care plan failed to indicate a problem of potential bruising as a result of the anticoagulant used, nor did the care plan indicate to monitor for signs/symptoms of bleeding (bruising, blood in urine, etc). On 4/12/18, at 11:58 a.m. registered nurse (RN)-H stated she was unaware of any incident reports regarding bruising for R58. RN-H verified R58 had self reported the bruise on her hand. RN-H verified no interventions were included in the care plan regarding the frequent bruising or use of the anticoagulant.	F 656	needed, by the RN Managers, to address their potential for bruising/bleeding as a result of the anticoagulant use. Measures put in place to prevent recurrence: The nurses were re-educated on the need to accurately assess and care plan the potential for bruising/bleeding for those residents on anticoagulant therapy. Plan to Monitor: All newly admitted/re-admitted residents will be audited for anticoagulant use by the RN Managers to ensure that a care plan is developed to address their potential risk for bruising/bleeding weekly x 3 months. Audit findings will be reviewed at monthly QAPI meetings and continue if warranted. Responsible for maintaining compliance: RN Mangers or designee/DON or designee/Staff Development	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 4 residents (R111 and R103) reviewed for activities of daily	F 677	F561 It is the policy of Woodbury Health Care Center (WHCC) to promote and facilitate	5/21/18

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F 677	Continued From page 9 living, received bathing/hygiene assistance and assistance with incontinence care. Findings include: R111's admission minimum data set (MDS) assessment dated 1/18/18, indicated R111 was cognitively intact, totally dependent on two or more staff for transferring between surfaces and required extensive assistance from two or more staff for personal hygiene. According to the MDS, R111 was coded as not having bathed during the assessment reference period. On 4/9/18 at 2:22 p.m., R111 stated during interview she was not being bathed frequently enough, and was unsure of her scheduled bath day. R111 stated staff had asked her to bathe late at night at times, and stated she had refused due to the late hour. R111 reported she felt she should be bathed at least weekly. On 4/10/18 at 11:15 a.m., during a follow up interview, R111 stated she had not been bathed for 3 weeks. R111 stated, "I smell all the time under my arms" and also stated she thought she smelled of feces. During the interview, R111's hair was noted to look oily and damp, and R111 did have a fecal odor. On 4/12/18 at 9:56 a.m. the registered nurse/unit manager (RN)-E, reported R111 had refused her bath the previous week due to the late hour it was offered. RN-E stated when a resident refused a bath on their scheduled weekly bath day, another opportunity should be offered that week. On 4/12/18 at 12:29 p.m., R111 was observed again to have oily hair matted to her head.	F 677	resident self determination through support of resident choice, including but not limited to the right to choose activities, schedules and health care consistent with his/her interests, assessments and plan of care. Plan of correction for residents cited with this survey: R128 was interviewed by the RN Manager 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 staff. Plan to address/prevent this deficiency for other residents: A 72 hour team based admission conference will be held for all admissions. Bathing preferences will be discussed with the resident and/or their representative at the meeting. Preferences will be further expanded upon during the Community Life (CL) interview for daily preferences assessment. Existing residents will be re-assessed for their bathing preference at the time of their next scheduled RAI/MDS assessment using the CL interview for daily preferences assessment. The residents' plan of care will be updated with the preferences, as needed. Care plan changes are communicated to the staff as changes are made. Measures put in place to prevent recurrence:	

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F 677	Continued From page 10 R111's care plan last revised on 2/5/18, included no direction related to bathing assistance. R111's undated nursing assistant care plan, indicated R111 required assistance of 2 staff for bathing and bed mobility, and 2 staff assistance with transferring with a full mechanical lift. The care plan also indicated R111 was scheduled to be bathed on Monday afternoons. R111's 30 day bathing record was reviewed and revealed R111 was totally dependent on staff for assistance during bathing on 3/19 and 3/26/18. On 4/2/18 and 4/9/18, the documentation indicated R111 had refused a bath during the evening hours. No other bathing opportunities were documented as offered. R111's Progress Notes dated 3/1 to 4/12/18, provided no further information related to bathing refusals or opportunities. The facility's Standards of Care Guidelines last revised 4/26/17, directed staff: "Bath/showers as scheduled. Weekly minimum of complete tub bath or shower. This includes body, nails, ears, hairs (men or those women not going to beauty shop). Use of deodorant to underarm. Lotion to dry skin areas. Nails are to be trimmed weekly or more often as needed. (Diabetic nail care is to be provided by the licensed staff). Bed bath per resident's care plan if unable to tolerate shower or tub bath." R103 was continually observed on 4/9/18, from 4:41 p.m.- 7:23 p.m. (2 hours 42 minutes). At 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,	F 677	Audits of the 72 hour team based admission conference assessment and the CL interview for daily preferences assessment will be conducted by the LSW Director or designee and CL Director or designee for 25% of the newly admitted residents weekly x 3 months to ensure, promote and facilitate resident self-determination. A new CL interview for daily preferences assessment will be conducted for all long term residents during their next scheduled RAI/MDS assessment to ensure their preferences are known and honored. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Plan to Monitor: Audits of the 72 hour team based admission conference assessment and the CL interview for daily preferences assessment will be conducted by the LSW Director or designee and CL Director or designee for 25% of the newly admitted residents weekly x 3 months to ensure the residents' preferences were documented during the interviews/conference and assessment, to promote and facilitate resident self-determination. A new CL interview for daily preferences assessment will be conducted for all long term residents during their next scheduled RAI/MDS assessment to ensure their preferences are known and honored. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Responsible for maintaining compliance:	

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F 677	Continued From page 11 and R103 in the Broda chair, was positioned by the foot of the bed by nursing assistant (NA)-B. At 7:21 p.m., NA-C verified R103 had not been checked for incontinence. NA-C stated R103 appeared tired, and confirmed R103 had been up prior to the start of his shift at 2:30 p.m. NA-C stated R103 had not been checked for incontinence since the start of the shift. 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 check R103 for incontinence. 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 of 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. 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 nursing assistants (NA-A, NA-B, NA-C, NA-D, and NA-E) walked past R103 without offering the resident any care. On 4/10/18 at 12:47 p.m., NA-A verified R103 had not been checked for incontinence since that morning at approximately 8:00 a.m. R103's admission record revealed R103 was admitted to the facility 6/7/17, with diagnosis including: anxiety disorder, major depressive disorder, mood (affective) disorder, Parkinson's	F 677	LSW Director or designee/Community Life Director or designee/ RN Manager or Designee	

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F 677	Continued From page 12 disease and dementia with behavior disturbance. A quarterly Minimum Data Set (MDS) assessment dated 3/14/18, indicated R103 required extensive assist of two with bed mobility, 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. A Care Area Assessment (CAA) dated 9/19/17, included: " ... requires extensive to total assist with all activities of daily living (ADL's) and mobility, and "is at risk for alteration in skin integrity and UTI's (urinary tract infections)". R103's care plan dated 7/3/17, directed staff, "requires assist of two for check and change upon rising, before and after meals, a bedtime and during night rounds..." The undated Nursing Assistant Assignment Sheet included the same guidance for staff. On 4/11/18 at 11:20 a.m., RN-C stated, "My expectation is nursing staff need to follow [R103's] plan of care that directs nursing staff." The facility's policy and procedure, Continence Evaluation dated 2014, included: "to evaluate each resident's continence status, determine an appropriate treatment or management program, assist residents in regaining continence to their highest practicable level of functioning, promote skin integrity, reduce potential for urinary tract infections, and promote a resident's independence and self-esteem."	F 677		

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R103) identified at risk for pressure ulcers (PU) received timely repositioning. Findings include: R103 was continually observed on 4/9/18, from 4:41 p.m.- 7:23 p.m. (2 hours 42 minutes). At 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 nursing assistant (NA)-B. At 7:21 p.m., NA-C verified R103 had not been repositioned. NA-C stated R103 appeared tired, and confirmed R103 had been up prior to the start of his shift at 2:30 p.m. NA-C stated R103 had not been repositioned since the start of the shift.	F 686	It is the policy of WHCC to ensure that residents identified as at risk for pressure ulcers receive timely repositioning. Plan of correction for residents cited with this survey: R103□s Comprehensive skin and positioning evaluation was reassessed on 5/2/18 with no changes noted from 3/12/18 assessment. R103□s plan of care was reviewed with the NAR□s by the RN Manager to ensure timely repositioning. R103 experienced no adverse consequences as a result of the cited practice and continues to be free of skin breakdown. Plan to address/prevent this deficiency for other residents: The RN Managers have reviewed all residents listed as at risk on the	5/21/18

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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 nursing assistants (NA-A, NA-B, NA-C, NA-D, and NA-E) walked past R103 without offering the resident any care including repositioning. On 4/10/18 at 12:47 p.m., NA-A verified R103 had not been offered to be repositioned since that morning at approximately 8:00 a.m. NA-A said she did not know why she had not repositioned R103. R103's admission record revealed R103 was admitted to the facility 6/7/17, with diagnosis including: anxiety disorder, major depressive disorder, mood (affective) disorder, Parkinson's disease and dementia with behavior disturbance. A quarterly Minimum Data Set (MDS) assessment dated 3/14/18, indicated R103 required extensive assist of two with bed mobility,	F 686	comprehensive skin and positioning evaluation assessment to ensure that a timely repositioning program is in place, the individualized programs have been communicated to the NAR□s and are on their plan of care. Measures put in place to prevent recurrence: Re-education was provided to the nursing staff to review the importance of timely positioning and following the plan of care to prevent the development of pressure ulcers. A weekly audit of 3-4 residents identified as being at risk per their comprehensive skin and positioning evaluation assessment will be conducted by the RN managers x 3 months to ensure timely repositioning and avoidance of pressure ulcer development. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Plan to Monitor: A weekly audit of 3-4 residents identified as being at risk per their comprehensive skin and positioning evaluation assessment will be conducted by the RN managers x 3 months to ensure timely repositioning and avoidance of pressure ulcer development. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Responsible for maintaining compliance: RN Mangers or designee/DON or designee/Staff Development	

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F 686	Continued From page 15 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. A Care Area Assessment (CAA) dated 9/19/17, included: " ... requires extensive to total assist with all activities of daily living (ADL's) and mobility, and "is at risk for alteration in skin integrity and UTI's (urinary tract infections)". R103's care plan dated 7/3/17, directed staff, "Encourage reposition/position changes during rounds and every 2 hours as able." The 11/16/17 care plan indicated, "[R103] has potential impairment to skin integrity due to impaired mobility, occasional poor appetite, use of wheelchair, incontinence..." The undated Nursing Assistant Assignment Sheet included: "Repos. Q2H (reposition every two hours) A-2 (assist of two)..." On 4/11/18 at 11:20 a.m., RN-C stated, "My expectation is nursing staff need to follow [R103's] plan of care that directs nursing staff to reposition resident every two hours."	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		5/21/18

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F 688	Continued From page 16 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff implemented a daily walking program as recommended by therapy, for 1 of 1 resident (R128) reviewed for mobility. Findings include: R128's admission record face sheet indicated an admission date of 8/29/17. R128's face sheet revealed diagnoses including generalized muscle weakness, lack of coordination, repeated falls, and absence of left leg below knee. A Minimum Data Set (MDS) assessment dated 3/19/18, indicated R128 was cognitively impaired with a BIMs (brief interview for mental status) score of 5. On 4/9/18 at 6:14 p.m., R128 was observed lying in bed, visiting with family member (F)-E. A prosthetic leg was observed propped against the wall behind the head of the bed. Although a blanket was covering the resident, R128's lower left leg was observed to be absent below the knee. When asked about whether R128 received	F 688	It is the policy of WHCC that residents with limited mobility receive appropriate services, equipment and assistance to maintain or improve mobility with maximum practicable independence unless unavoidable. Plan of correction for residents cited with this survey: R128□s walking program was verified with the Director of Therapy and communicated to the nursing staff by the RN Manager. R128□s care plan was updated to ensure the walking program was current and correct. R128 did not experience any adverse consequences as a result of the cited practice. Plan to address/prevent this deficiency for other residents: All residents receiving nursing restorative services have had their programs reviewed by the RN Managers and Restorative Aide to ensure that the	

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F 688	Continued From page 17 help needed from staff, F-E stated staff were supposed to walk with R128 daily Monday through Friday. F-E stated staff did not do this each weekday, and was concerned that it was leading to a decline in R128's mobility. F-E confirmed R128 had a prosthetic lower left leg, and required staff help to apply it. F-E further reported staff had not routinely been offering to walk with R128 each day and so F-E thought the resident was weaker now than before. F-E explained that R128 used to be able to walk down the hallway and back without a break but said, "today [R128] felt weak and needed to stop and rest halfway down the hall." R128's care plan revealed the resident had weakness and impairment in walking, balance, and range of motion due to a left below knee amputation with prosthesis. The care plan goals included increasing the current level of function and mobility, and using adaptive devices to increase R128's independence with activities of daily living. One of the interventions, initiated on 9/6/17, and revised 4/12/18, included a walking program to ambulate with assist of one staff 100-200 feet daily. During interview on 4/11/18 at 6:52 a.m., nursing assistant (NA)-F was asked about the restorative programming at the facility. NA-F explained how therapy created restorative programs for residents, such as daily walking programs or range of motion exercises. NA-F said all the nursing assistants, along with the restorative nursing assistant, worked together to carry out the restorative programs ordered for residents. NA-F said some days residents refuse to participate which was within their rights, but NA-F would then try to explain the benefits of	F 688	therapy established programs are being carried out as recommended. Measures put in place to prevent recurrence: The RN Managers will review all new restorative programs and/or changes to programs as they are handed off by therapy. The RN Managers will communicate the new programs or existing program changes to the nursing staff at daily stand-up meetings and update the plan of care. Nursing 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 services, equipment and assistance to improve or maintain their mobility. Plan to Monitor: The RN Managers or designee will audit 3 residents per week x 3 month that are on restorative programs to ensure the plan is implemented, documented, care planned and occurring on the floor. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Responsible for maintaining compliance: RN Mangers or designee/DON or designee/Restorative Aide	

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participation, and would re-approach the resident again later in the day. NA-F said would always tell a nurse if residents refused to participate, and explained that the nursing assistants were supposed to document daily in the nursing rehab task portion of the electronic medical record (eMR). NA-F said there were different options to clearly designate daily in the nursing rehab task if a resident refused to participate, if a resident was unavailable, or if the resident participated for the day.

A copy of the Nursing Rehab Task record was requested for the months of February, March, and April 2018. Staff provided the record for dates 3/14/18 - 4/12/18, which showed the following:

According to staff documentation, R128 walked on 12/23 days; R128 refused to walk on 8/23 days; R128 was not available to walk 1/23 days; and staff documented "Not Applicable" on 4/23 days. It was unclear what "Not Applicable" meant for the daily walking program. There were 7 days with no documentation at all, March 23, 24, 25 and April 2, 4, 7 and 8, 2018.

On 4/11/18, at 9:16 a.m., R128 was observed in bed. R128 stated he liked to go for walks sometimes, and confirmed the choice was up to R128. When asked how often staff offered to help R128 out of bed to go for a walk, R128 responded, "not too often."

On 4/11/18, at 2:00 p.m., NA-G was asked about R128's walking program. NA-G said nursing assistants were not supposed to walk with R128 right now, because R128 was having issues with walking and an ankle rolling. NA-G added that only the restorative nursing assistant and staff

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F 688	Continued From page 19	F 688		

from the therapy department were supposed to be walking with R128. At 2:01 p.m. NA-F said, "any nursing assistant is able to walk with [R128]" and added that the current order from therapy was to continue to walk with R128 once a day, 7 days a week, between 100-200 feet. NA-F explained that for a day there was a question about a newly observed walking concern, and nursing staff had waited for physical therapy to assess R128's walking for safety before continuing the walking program. However, NA-F said therapy had given staff verbal confirmation that nursing assistants were safe to continue the walking program as ordered, every day. At 2:06 p.m. NA-F asked R128 about going for a walk, and R128 agreed.

On 4/11/18 at 2:22 p.m., R128 was observed walking in the hall with NA-F, using a walker. Another staff followed R128 with a wheelchair in case the resident needed to sit and rest. After walking one length of the hall, R128 turned around to walk back, but stopped to rest in the wheelchair for a couple minutes. At 2:27 p.m. NA-F said R128 had walked about 110 feet so far, and was resting before finishing the walk back. NA-F pulled a current nursing assistant care sheet out of a cabinet, and reviewed it for R128's restorative program. NA-F confirmed the daily walking program of 100-200 feet was listed on the care sheet, and said that should happen seven days a week, including weekends.

On 4/11/18 at 2:37 p.m., R128 had finished walking and was resting in bed visiting with F-E. When asked how the resident was feeling, R128 said walking felt good today. R128 acknowledged feeling tired, and F-E stated R128 was previously able to walk without resting.

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F 688	Continued From page 20 On 4/11/18 at 2:42 p.m., the director of therapy (DT) was interviewed about R128's restorative walking program. DT said nursing assistants were suppose to offer to walk R128 every day. The DT said R128 does refuse to walk at times, but confirmed staff should still offer daily. In addition, the DT said there was a day or two when nursing staff may have been waiting to hear whether it was safe to walk with R128, but stated he had assessed R128 to be safe, and expected the walking program to continue as recommended. DT described a time when R128 was able to walk down the hall and back without stopping, but said R128 has had multiple hospitalizations since January 2018, and therapy would expect to see some decline due to that. On 4/12/18 at 3:14 p.m., registered nurse (RN)-F confirmed that if therapy wrote a recommendation for walking every day, then staff should offer to walk the resident seven days a week. A policy regarding rehabilitative nursing programs was requested, but not provided.	F 688		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		5/21/18

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F 761	Continued From page 21 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 5 of 14 residents (R80, R12, R67, R58 and R118) reviewed for medication storage. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R80, R12, R67, R58 and R118, which included Inhalers and Insulin pen/vial medications, lacked dates to indicate when they were opened, or when the medications expired. In addition, an insulin flexpen was missing the order label. During a medication storage on second floor on 4/11/18 at 10:24 a.m., with licensed practical nurse (LPN)-A, the long-term care second floor treatment cart was observed to have the following expired insulin available for use stored in the treatment cart:	F 761	It is the policy of WHCC to establish and maintain accurate labeling and dispensing of medications that have not expired. Plan of correction for residents cited with this survey: R80, R12, R67, R58 and R118 had the identified medications immediately discarded, replaced and properly labeled. No resident identified experienced any adverse consequences as a result of the cited practice. Plan to address/prevent this deficiency for other residents: An audit of all resident medications was conducted by the RN Managers to identify and correct any medications that have expired or require dates when opened to ensure compliance. Those out of compliance were removed, discarded, replaced and properly labeled.	

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F 761	Continued From page 22 R80's Novolog insulin vial was identified as opened on 2/24/18. R80's Lantus Solution pen was identified as opened on 1/22/18. R12's Lantus insulin pen was undated as to when it had been opened for use. At 10:39 a.m on 4/11/18, an Advair Diskus Aerosol inhaler for R67 was observed to be open, but not dated as to when it had been put into use. At 10:41 a.m., LPN-A verified medications should be labeled and stored properly. LPN-A stated she would remove the inhaler and replace it with a new inhaler from the medication storage room. During observations with registered nurse (RN)-A of the medication storage cart on the transitional care unit (TCU)on the first floor, on 4/11/18 at 10:44 a.m., two Advair Diskus Aerosol inhalers for R58 were observed to be opened for use, but were undated as to when opened. At 10:47 a.m., RN-A verified medications should be labeled and stored properly and stated she would remove the undated inhalers from the medication cart and update the director of nursing (DON). During observations with RN-B of the lower level TCU cart on 4/11/18 at 11:07 a.m., a Novolog insulin flexpen was observed to be opened, and it was dated 3/8/18. However, there was no label on the insulin pen. RN-B stated it was R118's Novolog flexpen, but verified the insulin pen lacked an appropriate label. RN-B stated she would remove the insulin pen from use and replace it with another insulin flex pen from the medication room refrigerator. During interview with the DON on 4/11/18 at 1:07 p.m., the DON stated she would ensure concerns about the medications identified would	F 761	Measures put in place to prevent recurrence: The policy and procedure for medication storage and labeling was reviewed and remains current and up to date. Nursing staff that administer medication have been re-educated on the policy and procedure. Medication and treatment carts will be inspected weekly by the RN Managers or designee to ensure compliance. Plan to Monitor: RN Mangers or designee will conduct weekly audits of 1 medication room and 1 medication or treatment cart monthly x 3. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Responsible for maintaining compliance: RN Managers or designee/Nursing staff that administer medication/DON or designee	

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F 761	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."	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		5/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, MN 55125**

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F 812	Continued From page 24 (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 review, the facility failed to ensure dishes were air dried prior to storing, and failed to ensure supplements were dated when thawed. This had the potential to impact all six residents residing on the lower level and 10 residents who received prescribed supplements. Findings include: On 4/12/18, at 1:33 p.m. the kitchen and unit kitchenettes were toured. Two dietary aides (DA)-A and DA-B were observed grabbing dishes from the clean side of the dish machine and putting them in storage wet, stacking plates wet in the plate holder, putting wet scoops and utensils in the drawers, stacking racks of wet cups on top of dry racks of cups, stacking wet bowls in the metal carts and stacking wet trays in floor carts. At that time, the dietary manager (DM) confirmed this finding, noting drops of water on dishes. The DM stated dishes were supposed to be air dried, and added she'd purchased a special product for the dishwasher to ensure quick drying. DA-B	F 812	It is the policy of WHCC to store, prepare, and distribute food in accordance with professional standards for food service safety. Plan of Correction for issues cited in survey: Undated food items were immediately disposed of. Dishwashing staff were immediately re-educated to the company dish machine policy. No residents were adversely affected by this cited practice Plan to address/prevent this deficiency for other residents: All dietary staff were re-educated on company dish machine policy and procedure. This dish machine policy will be part of the new staff orientation. All dietary staff were re-educated on the company supplement labeling and dating policy. The closing checklist was updated to include nightly inspections of the kitchenette refrigerators for correct	

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F 812	Continued From page 25 verified she was trained to put the dishes away dry. The DM stated the dishes being stacked wet were for the residents residing on the lower level who received room trays. A tour of the unit refrigerators revealed: 1st floor: 5 orange supplements thawed and undated, 2nd floor: 4 orange supplements stored thawed and undated, and 3rd floor: 2 protein shakes stored thawed and undated. According to directions on the containers, staff were not to serve the supplements more than 14 days after thawed. The DM confirmed the supplements should have been dated when taken out to thaw. The facility's Dishmachine Policy dated 6/15/17, included: "air-dry all items. Do not stack or nest wet items." The facility's Food Labeling policy dated 6/15/17, included: "Each label must contain the following information: product name (or a common name or identifying description), use by date, date the product was prepared or opened, time prepared and team member initials where applicable, date frozen, if applicable, and date thawed, if applicable."	F 812	labeling and dating of food items. Plan to Monitor: RD/FSD will conduct random audits/observation weekly x3/months of dishwashing, drying and storing of dishes. RD/FSD will perform audits of unit refrigerators weekly x3/months to assure 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 company labeling and dating policy. All audit findings will be reported on at the monthly QAPI meeting. Responsible for maintaining compliance: RD and FSD	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		5/21/18

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F 880	Continued From page 26 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880		

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F 880	Continued From page 27 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to minimize the risk for spead of infection related to the handling and cleansing of a blood glucose meter (device used to test blood sugars) for 1 of 1 (R118) resident reviewed. Findings include: On 4/9/18 at 12:44 p.m., licensed practical nurse (LPN)-A was observed to wear gloves when she wiped R118's finger with an alcohol wipe, poked R118's finger with a single use lancet, obtained a drop of blood with a test strip she inserted into the glucometer to determine blood sugar results. LPN-A then put the used glucometer on top of the plastic container of single use unused lancets. LPN-wrapped a sanitizing wipe around the glucometer and let it rest on the cart for several minutes, however, the wrap did not cover the ends of the glucometer, including the end where	F 880	It is the policy of WHCC to minimize the risk for spread of infection related to handling and cleaning blood glucose meters. Plan of correction for residents cited with this survey: LPN-A was immediately re-educated on the proper handling and cleaning of the blood glucose meter. R118 experienced no observable adverse consequence as a result of the cited practice. Plan to address/prevent this deficiency for other residents: Re-education was provided to the nursing staff that performs blood glucose checks via a meter to ensure that the risk to spread infection is minimized as related to handling and cleaning of the blood glucose meters.	

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F 880	Continued From page 28 the test strip was inserted. LPN-A wiped the glucometer for about 10 seconds and put it in medication cart. Immediately after, LPN-A took the glucometer out of the medication cart upon request and confirmed it was not still wet. LPN-A acknowledged the glucometer was on the lancets and said that was "not good." LPN-A then said the lancets would need to be disposed. On 4/12/18 at 3:15 p.m. the assistant director of nursing and registered nurse (RN)-F, reported a dirty glucometer should not be placed on top of clean lancets and the glucometer should be thoroughly cleaned. RN-F confirmed the glucometers were used for multiple patients. The facility's Blood Glucose Testing policy last revised 9/2017, included: "To disinfect the meter; Use a Sani-Cloth Super Wipe. a) Remove wipe from container. b) Thoroughly wipe down the meter c) If wipe is very saturated, wring out excess so as not to damage the test strip and key code ports during cleaning. d) Contact time for keeping the glucometer moistened with the Sani-Wipe is 2 minutes. To ensure the glucometer remains moist, either wipe meter down for two full minutes or wrap the meter in the wipe after thoroughly wiping it down. e) After two full minutes place the meter on a clean surface to allow the glucometer to dry. f) Perform hand hygiene."	F 880	Measures put in place to prevent recurrence: Re-education was provided to the nursing staff that performs blood glucose checks via a meter to ensure that the risk to spread infection is minimized as related to handling and cleaning of the blood glucose meters. RN Managers will conduct weekly audits observing nurses handling and cleaning blood glucose meters during use on 3-4 residents per week x 3 months. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Plan to Monitor: RN Managers will conduct weekly audits observing nurses handling and cleaning blood glucose meters during use on 3-4 residents per week x 3 months. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Responsible for maintaining compliance: RN Managers or designee/Nurses that perform blood glucose checks via meter/Infection Preventionist/DON or designee	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-	F 883		5/21/18

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F 883	Continued From page 29 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		

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F 883	Continued From page 30 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to offer pneumococcal immunization to 3 of 5 residents (R117, R45, R8) reviewed for immunizations. Findings include: The facility's Pneumococcal Vaccine Practice guideline and procedure revised 9/17, included: "The pneumococcal polysaccharide vaccine (PPSV23) or pneumococcal conjugate vaccine (PCV13), is offered to all residents 65 years of age and over at admission....The resident will be given the opportunity to refuse the vaccine. The choice will be documented in the medical record." Regarding timelines of administration, the procedure guided "All adults 65 years of age or older receive a dose of PCV13 followed by a dose of PPSV23 at least 1 year later." The guidance continued, "Adults 65 or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." The procedure required orders to be obtained upon admission to administer the pneumococcal	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: R117, R45 and R8 have been offered pneumococcal immunization and their immunization records have been updated. 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 pneumococcal immunization has been offered and that education was provided regarding the benefits and potential side effects of the pneumococcal immunization. The LPN	

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F 883	Continued From page 31 vaccine, and to obtain consents when possible. The procedure directed nursing staff to attempt to determine prior vaccinations history through MIIC (Minnesota Immunization Information Connection), the resident's primary care clinic, previous long term care facilities, and through family/resident interview. Review of the immunizations tab in the electronic medical record revealed the following: R117 was admitted to the facility on 3/8/18, and had received a historical "Pneumovax Dose 1" in 2000. There was no documentation that a second pneumococcal vaccination had been offered or administered after admission. R45 was admitted to the facility on 10/28/17, and had received a historical "Pneumovax Dose 1" in 2014. There was no documentation that a second pneumococcal vaccination had been offered or administered after admission. R8 was admitted to the facility on 9/15/17, and did not have any historical pneumococcal immunization history documented. Additionally, there was no documentation that the facility had offered or administered the vaccination to R8 after admission. During interview on 4/12/18 at 3:26 p.m., registered nurse (RN)-F said that nursing staff on the floors were currently tracking pneumococcal immunizations. RN-F said staff used MIIC to try and figure out which vaccinations newly admitted residents had already received, and to determine which residents were due, but said the facility may need a stronger process. RN-F confirmed that if a resident's immunizations tab in the	F 883	admissions nurse and/or HUC□s will reference MIIC upon resident admission to reference historical data regarding the resident□s immunization status and enter findings into the resident□s medical record under the immunization tab. An audit of all long term residents□ pneumococcal immunization status was conducted by the RN Managers. Residents found to having missing pneumococcal immunization data will be offered immunization after education is provided regarding the benefits and potential side effects of the pneumococcal immunization. This will be done at the time of the resident□s next scheduled care conference/RAI/MDS assessment and documented in the resident□s medical record under the immunization tab. Measures put in place to prevent recurrence: Nursing staff have received education on the importance of offering/administering and documenting pneumococcal immunizations. 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 pneumococcal immunization has been offered and that education was provided regarding the benefits and potential side effects of the pneumococcal immunization. The LPN admissions nurse and/or HUC□s will reference MIIC upon resident admission to reference historical	

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F 883	Continued From page 32 electronic medical record was incomplete, it was possible that the pneumococcal vaccination was not offered.	F 883	data regarding the resident□s immunization status and enter findings into the resident□s medical record under the immunization tab. An audit of all long term residents□ pneumococcal immunization status was conducted by the RN Managers. Residents found to having missing pneumococcal immunization data will be offered immunization after education is provided regarding the benefits and potential side effects of the pneumococcal immunization. This will be done at the time of the resident□s next scheduled care conference/RAI/MDS 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 was conducted by the RN managers. The audit will be cross-referenced with the RAI/MDS schedule weekly x 3 months to ensure that the RN managers provide education regarding the benefits and potential side effects of the immunization, offer the pneumococcal immunization and enter all pertinent data into the resident□s medical record/immunization tab for all residents identified in the audit as having missing pneumococcal immunization data. Audit findings and progress made in updating/educating and offering pneumococcal immunization for those residents identified will be presented at the monthly QAPI meetings and continue until all long term residents found to have missing immunization data have been	

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F 883	Continued From page 33	F 883	offered/educated and documented as required. The Infection Preventionist will audit 10% of newly admitted residents weekly x 3months to ensure compliance. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Responsible for maintaining compliance: Infection Preventionist/RN Managers or designee/DON or deignee	

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	245235	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/11/2018**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Woodbury Healthcare Center) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Woodbury Healthcare Center is a 4-story building with no basement. The building was constructed at 2 different times. The original 3 story building was constructed in 1979 and was determined to be of Type II(222) construction. In 1986, a fourth floor addition was constructed that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 175 beds and had a census of 135 at the time of the survey.	K 000		

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

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00803	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/9/18 through 4/12/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, complaint investigations were also completed at the time of the licensing survey. An investigation of complaints H5235086, H5235088, H5235089, and H5235090 were completed. The complaints were not substantiated. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings	2 000		

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2 000	Continued From page 2 are the Suggested Method of Correction and 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.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents (R123) reviewed for falls. Findings include: R123's Admission Record indicated R123 had diagnoses including Alzheimer's disease, anxiety disorder, major depression, legal blindness, diabetes mellitus and repeated falls. R123's annual MDS dated 3/21/18, failed to accurately reflect falls with or without minor/major	2 550	Corrected	5/21/18

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2 550	Continued From page 3	2 550		

injury. The 3/21/18 MDS was coded to indicate R123 had experienced one fall with no injury, two or more falls with minor injury and two or more falls with major injury from falls since admission or prior assessment, whichever was more recently related to a fall.

R123's progress note dated 1/6/18, at 4:34 p.m., included: "... Resident found laying [lying] on right side in her bathroom. 1.5 cm (centimeters) X 0.2 cm laceration to right occipital area. Bleeding controlled. Dressed with gauze and stretch kerlex.. Control bleeding and initiate long neuro checks and vitals. NARs (nursing assistant registered) instructed to complete frequent visual monitoring on resident through the remainder of the evening shift..."

R123's progress note dated 1/14/18, at 6:26 a.m., included: "Resident found on the floor during last hourly rounds. Resident was lying on her left side in her room next to her bed. No injuries noted, denies hitting head and denies pain..."

R123's progress note dated 1/20/18, at 9:58 p.m., included: "At 20:04 (8:04 p.m.) resident was found on the floor in her room near the commode, face down. L (left) eye and surrounding swollen ... Ice pack on L eye ..."

An incident report for R123 dated 2/22/18, included: "Resident was found on her bathroom floor with her pants half down. Resident denies hitting head, denies pain."

On 4/12/18, at 12:47 p.m. registered nurse (RN)-D verified after reviewing the medical record that the annual MDS assessment dated 3/21/18, had not been coded accurately to reflect R123's falls. RN-D stated the facility would modify the

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2 550	Continued From page 4 MDS because R123 had experienced two falls without injuries, two falls with minor injuries and no falls with major injuries. RN-D indicated the major injury section had been auto filled from a previous MDS. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated October 2017, "... Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall ... Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the accuracy of assessments. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are	2 560		5/21/18

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2 560	Continued From page 5 identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to address the use of an anticoagulant with bruising for 1 of 1 resident (R58) in the sample. Findings include: On 4/10/18 at 9:43 a.m., R58 stated during interview she had bruises on her right lower arm from hitting the grab bar, and bruises on her upper thighs. R58 pointed to her right upper arm and small dark colored spots were observed. On 4/12/18 at 9:58 a.m., R58 was observed resting in bed, covered with blankets. Her breakfast tray was on the tray table in front of her when a staff nurse brought in her medications. R58 was complaining of leg discomfort and the staff nurse removed the blanket to assess R58's leg. R58's upper right leg was observed to have several small discolored areas, less that 1 cm in size on the leg. R58's right forearm was also noted to have a scattering of small discolored marks. R58's admission record indicated she'd been admitted to the facility on 7/29/17. The admission minimum data set (MDS) assessment dated 8/5/17, indicated R58 's cognition was intact with a BIMS (brief interview for mental status) score of 14, indicating cognition was good. The MDS further indicated R58 had no behavioral concerns	2 560	Corrected	

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2 560	Continued From page 6 and indicated R58 was on an anticoagulant. A review of physician orders indicated R58 had an order for eliquis (a blood thinner) to be administered orally every day. The care plan, last updated on 9/15/17, indicated R58 had diagnoses that included hypertension, history of cerebral infarction, and atrial fibrillation. The care plan failed to indicate a problem of potential bruising as a result of the anticoagulant used, nor did the care plan indicate to monitor for signs/symptoms of bleeding (bruising, blood in urine, etc). On 4/12/18, at 11:58 a.m. registered nurse (RN)-H stated she was unaware of any incident reports regarding bruising for R58. RN-H verified R58 had self reported the bruise on her hand. RN-H verified no interventions were included in the care plan regarding the frequent bruising or use of the anticoagulant. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan is individualized for each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff included individual needs in the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program	2 895		5/21/18

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2 895	Continued From page 7 that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff implemented a daily walking program as recommended by therapy, for 1 of 1 resident (R128) reviewed for mobility. Findings include: R128's admission record face sheet indicated an admission date of 8/29/17. R128's face sheet revealed diagnoses including generalized muscle weakness, lack of coordination, repeated falls, and absence of left leg below knee. A Minimum Data Set (MDS) assessment dated 3/19/18, indicated R128 was cognitively impaired with a BIMs (brief interview for mental status) score of 5. On 4/9/18 at 6:14 p.m., R128 was observed lying in bed, visiting with family member (F)-E. A prosthetic leg was observed propped against the wall behind the head of the bed. Although a blanket was covering the resident, R128's lower left leg was observed to be absent below the knee. When asked about whether R128 received	2 895	Corrected	

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2 895	Continued From page 8	2 895		

help needed from staff, F-E stated staff were supposed to walk with R128 daily Monday through Friday. F-E stated staff did not do this each weekday, and was concerned that it was leading to a decline in R128's mobility. F-E confirmed R128 had a prosthetic lower left leg, and required staff help to apply it. F-E further reported staff had not routinely been offering to walk with R128 each day and so F-E thought the resident was weaker now than before. F-E explained that R128 used to be able to walk down the hallway and back without a break but said, "today [R128] felt weak and needed to stop and rest halfway down the hall."

R128's care plan revealed the resident had weakness and impairment in walking, balance, and range of motion due to a left below knee amputation with prosthesis. The care plan goals included increasing the current level of function and mobility, and using adaptive devices to increase R128's independence with activities of daily living. One of the interventions, initiated on 9/6/17, and revised 4/12/18, included a walking program to ambulate with assist of one staff 100-200 feet daily.

During interview on 4/11/18 at 6:52 a.m., nursing assistant (NA)-F was asked about the restorative programming at the facility. NA-F explained how therapy created restorative programs for residents, such as daily walking programs or range of motion exercises. NA-F said all the nursing assistants, along with the restorative nursing assistant, worked together to carry out the restorative programs ordered for residents. NA-F said some days residents refuse to participate which was within their rights, but NA-F would then try to explain the benefits of participation, and would re-approach the resident

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2 895	Continued From page 9	2 895		

again later in the day. NA-F said would always tell a nurse if residents refused to participate, and explained that the nursing assistants were supposed to document daily in the nursing rehab task portion of the electronic medical record (eMR). NA-F said there were different options to clearly designate daily in the nursing rehab task if a resident refused to participate, if a resident was unavailable, or if the resident participated for the day.

A copy of the Nursing Rehab Task record was requested for the months of February, March, and April 2018. Staff provided the record for dates 3/14/18 - 4/12/18, which showed the following:

According to staff documentation, R128 walked on 12/23 days; R128 refused to walk on 8/23 days; R128 was not available to walk 1/23 days; and staff documented "Not Applicable" on 4/23 days. It was unclear what "Not Applicable" meant for the daily walking program. There were 7 days with no documentation at all, March 23, 24, 25 and April 2, 4, 7 and 8, 2018.

On 4/11/18, at 9:16 a.m., R128 was observed in bed. R128 stated he liked to go for walks sometimes, and confirmed the choice was up to R128. When asked how often staff offered to help R128 out of bed to go for a walk, R128 responded, "not too often."

On 4/11/18, at 2:00 p.m., NA-G was asked about R128's walking program. NA-G said nursing assistants were not supposed to walk with R128 right now, because R128 was having issues with walking and an ankle rolling. NA-G added that only the restorative nursing assistant and staff from the therapy department were supposed to be walking with R128. At 2:01 p.m. NA-F said,

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2 895	Continued From page 10	2 895		

"any nursing assistant is able to walk with [R128]" and added that the current order from therapy was to continue to walk with R128 once a day, 7 days a week, between 100-200 feet. NA-F explained that for a day there was a question about a newly observed walking concern, and nursing staff had waited for physical therapy to assess R128's walking for safety before continuing the walking program. However, NA-F said therapy had given staff verbal confirmation that nursing assistants were safe to continue the walking program as ordered, every day. At 2:06 p.m. NA-F asked R128 about going for a walk, and R128 agreed.

On 4/11/18 at 2:22 p.m., R128 was observed walking in the hall with NA-F, using a walker. Another staff followed R128 with a wheelchair in case the resident needed to sit and rest. After walking one length of the hall, R128 turned around to walk back, but stopped to rest in the wheelchair for a couple minutes. At 2:27 p.m. NA-F said R128 had walked about 110 feet so far, and was resting before finishing the walk back. NA-F pulled a current nursing assistant care sheet out of a cabinet, and reviewed it for R128's restorative program. NA-F confirmed the daily walking program of 100-200 feet was listed on the care sheet, and said that should happen seven days a week, including weekends.

On 4/11/18 at 2:37 p.m., R128 had finished walking and was resting in bed visiting with F-E. When asked how the resident was feeling, R128 said walking felt good today. R128 acknowledged feeling tired, and F-E stated R128 was previously able to walk without resting.

On 4/11/18 at 2:42 p.m., the director of therapy (DT) was interviewed about R128's restorative

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2 895	Continued From page 11 walking program. DT said nursing assistants were suppose to offer to walk R128 every day. The DT said R128 does refuse to walk at times, but confirmed staff should still offer daily. In addition, the DT said there was a day or two when nursing staff may have been waiting to hear whether it was safe to walk with R128, but stated he had assessed R128 to be safe, and expected the walking program to continue as recommended. DT described a time when R128 was able to walk down the hall and back without stopping, but said R128 has had multiple hospitalizations since January 2018, and therapy would expect to see some decline due to that. On 4/12/18 at 3:14 p.m., registered nurse (RN)-F confirmed that if therapy wrote a recommendation for walking every day, then staff should offer to walk the resident seven days a week. A policy regarding rehabilitative nursing programs was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the restorative nursing care plan for each individual resident is followed. The DON could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care regarding mobility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers	2 900		5/21/18

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2 900	Continued From page 12 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R103) identified at risk for pressure ulcers (PU) received timely repositioning. Findings include: R103 was continually observed on 4/9/18, from 4:41 p.m.- 7:23 p.m. (2 hours 42 minutes). At 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 nursing assistant (NA)-B. At 7:21 p.m., NA-C verified R103 had not been repositioned. NA-C stated R103 appeared tired, and confirmed R103 had been up prior to the start of his shift at 2:30 p.m. NA-C stated R103 had not been repositioned since the start of the shift.	2 900	Corrected	

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2 900	Continued From page 13 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 nursing assistants (NA-A, NA-B, NA-C, NA-D, and NA-E) walked past R103 without offering the resident any care including repositioning. On 4/10/18 at 12:47 p.m., NA-A verified R103 had not been offered to be repositioned since that morning at approximately 8:00 a.m. NA-A said she did not know why she had not repositioned R103. R103's admission record revealed R103 was admitted to the facility 6/7/17, with diagnosis including: anxiety disorder, major depressive disorder, mood (affective) disorder, Parkinson's disease and dementia with behavior disturbance. A quarterly Minimum Data Set (MDS) assessment dated 3/14/18, indicated R103 required extensive assist of two with bed mobility,	2 900		

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2 900	Continued From page 14 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. A Care Area Assessment (CAA) dated 9/19/17, included: " ... requires extensive to total assist with all activities of daily living (ADL's) and mobility, and "is at risk for alteration in skin integrity and UTI's (urinary tract infections)". R103's care plan dated 7/3/17, directed staff, "Encourage reposition/position changes during rounds and every 2 hours as able." The 11/16/17 care plan indicated, "[R103] has potential impairment to skin integrity due to impaired mobility, occasional poor appetite, use of wheelchair, incontinence..." The undated Nursing Assistant Assignment Sheet included: "Repos. Q2H (reposition every two hours) A-2 (assist of two)..." On 4/11/18 at 11:20 a.m., RN-C stated, "My expectation is nursing staff need to follow [R103's] plan of care that directs nursing staff to reposition resident every two hours." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for	2 900		

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2 900	Continued From page 15 pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 4 residents (R111 and R103) reviewed for activities of daily living, received bathing/hygiene assistance and assistance with incontinence care. Findings include: R111's admission minimum data set (MDS) assessment dated 1/18/18, indicated R111 was cognitively intact, totally dependent on two or more staff for transferring between surfaces and required extensive assistance from two or more staff for personal hygiene. According to the MDS, R111 was coded as not having bathed during the assessment reference period. On 4/9/18 at 2:22 p.m., R111 stated during interview she was not being bathed frequently enough, and was unsure of her scheduled bath day. R111 stated staff had asked her to bathe late	2 920	Corrected	5/21/18

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2 920	Continued From page 16 at night at times, and stated she had refused due to the late hour. R111 reported she felt she should be bathed at least weekly. On 4/10/18 at 11:15 a.m., during a follow up interview, R111 stated she had not been bathed for 3 weeks. R111 stated, "I smell all the time under my arms" and also stated she thought she smelled of feces. During the interview, R111's hair was noted to look oily and damp, and R111 did have a fecal odor. On 4/12/18 at 9:56 a.m. the registered nurse/unit manager (RN)-E, reported R111 had refused her bath the previous week due to the late hour it was offered. RN-E stated when a resident refused a bath on their scheduled weekly bath day, another opportunity should be offered that week. On 4/12/18 at 12:29 p.m., R111 was observed again to have oily hair matted to her head. R111's care plan last revised on 2/5/18, included no direction related to bathing assistance. R111's undated nursing assistant care plan, indicated R111 required assistance of 2 staff for bathing and bed mobility, and 2 staff assistance with transferring with a full mechanical lift. The care plan also indicated R111 was scheduled to be bathed on Monday afternoons. R111's 30 day bathing record was reviewed and revealed R111 was totally dependent on staff for assistance during bathing on 3/19 and 3/26/18. On 4/2/18 and 4/9/18, the documentation indicated R111 had refused a bath during the evening hours. No other bathing opportunities were documented as offered. R111's Progress Notes dated 3/1 to 4/12/18,	2 920		

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2 920	Continued From page 17	2 920		

provided no further information related to bathing refusals or opportunities.

The facility's Standards of Care Guidelines last revised 4/26/17, directed staff: "Bath/showers as scheduled. Weekly minimum of complete tub bath or shower. This includes body, nails, ears, hairs (men or those women not going to beauty shop). Use of deodorant to underarm. Lotion to dry skin areas. Nails are to be trimmed weekly or more often as needed. (Diabetic nail care is to be provided by the licensed staff). Bed bath per resident's care plan if unable to tolerate shower or tub bath."

R103 was continually observed on 4/9/18, from 4:41 p.m.- 7:23 p.m. (2 hours 42 minutes). At 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 nursing assistant (NA)-B. At 7:21 p.m., NA-C verified R103 had not been checked for incontinence. NA-C stated R103 appeared tired, and confirmed R103 had been up prior to the start of his shift at 2:30 p.m. NA-C stated R103 had not been checked for incontinence since the start of the shift.

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 check R103 for incontinence. 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 of bowel and bladder. During the observation at 12:52 p.m., R103's incontinent pad was observed to be

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2 920	Continued From page 18 soiled with a small amount of feces, and was saturated with urine. 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 nursing assistants (NA-A, NA-B, NA-C, NA-D, and NA-E) walked past R103 without offering the resident any care. On 4/10/18 at 12:47 p.m., NA-A verified R103 had not been checked for incontinence since that morning at approximately 8:00 a.m. R103's admission record revealed R103 was admitted to the facility 6/7/17, with diagnosis including: anxiety disorder, major depressive disorder, mood (affective) disorder, Parkinson's disease and dementia with behavior disturbance. A quarterly Minimum Data Set (MDS) assessment dated 3/14/18, indicated R103 required extensive assist of two with bed mobility, 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. A Care Area Assessment (CAA) dated 9/19/17, included: " ... requires extensive to total assist with all activities of daily living (ADL's) and mobility, and "is at risk for alteration in skin integrity and UTI's (urinary tract infections)". R103's care plan dated 7/3/17, directed staff, "requires assist of two for check and change	2 920		

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2 920	Continued From page 19 upon rising, before and after meals, a bedtime and during night rounds..." The undated Nursing Assistant Assignment Sheet included the same guidance for staff. On 4/11/18 at 11:20 a.m., RN-C stated, "My expectation is nursing staff need to follow [R103's] plan of care that directs nursing staff." The facility's policy and procedure, Continence Evaluation dated 2014, included: "to evaluate each resident's continence status, determine an appropriate treatment or management program, assist residents in regaining continence to their highest practicable level of functioning, promote skin integrity, reduce potential for urinary tract infections, and promote a resident's independence and self-esteem." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring residents who require assistance with ADLs receive timely assistance to meet their needs. The DON or designee could educate staff on policies and procedures. The DON or designee could audit to ensure compliance and report progress to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in	21015		5/21/18

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21015	Continued From page 20 the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishes were air dried prior to storing, and failed to ensure supplements were dated when thawed. This had the potential to impact all six residents residing on the lower level and 10 residents who received prescribed supplements. Findings include: On 4/12/18, at 1:33 p.m. the kitchen and unit kitchenettes were toured. Two dietary aides (DA)-A and DA-B were observed grabbing dishes from the clean side of the dish machine and putting them in storage wet, stacking plates wet in the plate holder, putting wet scoops and utensils in the drawers, stacking racks of wet cups on top of dry racks of cups, stacking wet bowls in the metal carts and stacking wet trays in floor carts. At that time, the dietary manager (DM) confirmed this finding, noting drops of water on dishes. The DM stated dishes were supposed to be air dried, and added she'd purchased a special product for the dishwasher to ensure quick drying. DA-B verified she was trained to put the dishes away dry. The DM stated the dishes being stacked wet were for the residents residing on the lower level who received room trays. A tour of the unit refrigerators revealed: 1st floor: 5 orange supplements thawed and undated, 2nd floor: 4 orange supplements stored thawed and undated, and 3rd floor: 2 protein shakes stored thawed and undated. According to directions on the containers, staff were not to serve the	21015	Corrected	

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21015	Continued From page 21 supplements more than 14 days after thawed. The DM confirmed the supplements should have been dated when taken out to thaw. The facility's Dishmachine Policy dated 6/15/17, included: "air-dry all items. Do not stack or nest wet items." The facility's Food Labeling policy dated 6/15/17, included: "Each label must contain the following information: product name (or a common name or identifying description), use by date, date the product was prepared or opened, time prepared and team member initials where applicable, date frozen, if applicable, and date thawed, if applicable." SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could review and revise, as needed policies and procedures for washing, drying and storing dishes, and labeling of foods when opened. The dietary manager or designee could educate staff on these policies and audit to ensure compliance. The dietary manager could report progress and compliance to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		5/21/18

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21375	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to minimize the risk for spead of infection related to the handling and cleansing of a blood glucose meter (device used to test blood sugars) for 1 of 1 (R118) resident reviewed. Findings include: On 4/9/18 at 12:44 p.m., licensed practical nurse (LPN)-A was observed to wear gloves when she wiped R118's finger with an alcohol wipe, poked R118's finger with a single use lancet, obtained a drop of blood with a test strip she inserted into the glucometer to determine blood sugar results. LPN-A then put the used glucometer on top of the plastic container of single use unused lancets. LPN-wrapped a sanitizing wipe around the glucometer and let it rest on the cart for several minutes, however, the wrap did not cover the ends of the glucometer, including the end where the test strip was inserted. LPN-A wiped the glucometer for about 10 seconds and put it in medication cart. Immediately after, LPN-A took the glucometer out of the medication cart upon request and confirmed it was not still wet. LPN-A acknowledged the glucometer was on the lancets and said that was "not good." LPN-A then said the lancets would need to be disposed. On 4/12/18 at 3:15 p.m. the assistant director of nursing and registered nurse (RN)-F, reported a dirty glucometer should not be placed on top of clean lancets and the glucometer should be thoroughly cleaned. RN-F confirmed the glucometers were used for multiple patients.	21375	Corrected	

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21375	Continued From page 23 The facility's Blood Glucose Testing policy last revised 9/2017, included: "To disinfect the meter; Use a Sani-Cloth Super Wipe. a) Remove wipe from container. b) Thoroughly wipe down the meter c) If wipe is very saturated, wring out excess so as not to damage the test strip and key code ports during cleaning. d) Contact time for keeping the glucometer moistened with the Sani-Wipe is 2 minutes. To ensure the glucometer remains moist, either wipe meter down for two full minutes or wrap the meter in the wipe after thoroughly wiping it down. e) After two full minutes place the meter on a clean surface to allow the glucometer to dry. f) Perform hand hygiene." SUGGESTED METHOD OF CORRECTION: The infection preventionist or designee could review and revise policies related to cleaning glucometers. The infection preventionist could educate all staff and perform audits to ensure compliance. The infection preventionist could report results of audits to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR).	21426		5/21/18

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21426	Continued From page 24 This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure appropriate tuberculosis (TB) screening according to facility policy and the Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, was conducted for 4 of 5 residents (R117, R128, R45, R8) reviewed for TB screening. Findings include: Review of the MDH guideline Regulations for Tuberculosis Control in Minnesota Health Care Settings (version July 2013) revealed that the baseline TB screening of residents in nursing homes consists of three components: assessing for current symptoms of active TB disease, assessing for TB risk factors and TB history, and testing for the presence of infection by administering either a two-step TST (tuberculin skin test) or single blood test. Facility policy titled TB Infection Control Plan, last	21426	Corrected	

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21426	Continued From page 25 revised 1/18, was consistent with the MDH guideline, in that it required the resident TB screening to be initiated within 72 hours of admission or within 90 days prior to admission, and to include an assessment of risk factors for TB, and any current TB symptoms, and a two-step TST or a single blood test. Additionally, the policy required that residents who refuse the TST should receive a single blood test, and residents who refuse both the TST and blood test should have a chest x-ray to rule out infectious TB disease. To document skin test results, the facility policy required staff to record the date of administration, the number of millimeters of induration, and interpretation of results (positive or negative). Review of resident TB screening records in the electronic medical record (eMR) revealed the following: R117 was admitted on 3/8/18. R117's provider refused to order the two step TST on 3/8/18. No documentation of a blood test or chest x-ray was provided. R128 was admitted on 8/29/17. Screening was not initiated within 72 hours of admission. The first step TST was given 9/7/17. The TB symptom screen, using the TB Screening Tool, was dated 1/7/18. R45 was admitted on 10/28/17, but no symptom screen (TB Screening Tool) was provided. R8 was admitted on 9/15/17, and received a second step TST on 9/24/17, but the interpretation and millimeters of induration were not documented.	21426		

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21426	Continued From page 26 During interview on 4/12/18 at 3:45 p.m., registered nurse (RN)-F said documentation for the TB testing should be in the electronic medical record under the immunizations' tab. RN-F confirmed that a TST reading without documented interpretation and millimeters of induration would be incorrect. RN-F was unable to find an earlier TB symptom screen for R128, and was unable to find the TB screening tool at all for R45. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all residents are screened for TB within the appropriate timeframes upon admission, and staff complete and maintain proper documentation of the screening process. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 5 of 14	21620	Corrected	5/21/18

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21620	Continued From page 27 residents (R80, R12, R67, R58 and R118) reviewed for medication storage. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R80, R12, R67, R58 and R118, which included Inhalers and Insulin pen/vial medications, lacked dates to indicate when they were opened, or when the medications expired. In addition, an insulin flexpen was missing the order label. During a medication storage on second floor on 4/11/18 at 10:24 a.m., with licensed practical nurse (LPN)-A, the long-term care second floor treatment cart was observed to have the following expired insulin available for use stored in the treatment cart: R80's Novolog insulin vial was identified as opened on 2/24/18. R80's Lantus Solution pen was identified as opened on 1/22/18. R12's Lantus insulin pen was undated as to when it had been opened for use. At 10:39 a.m on 4/11/18, an Advair Diskus Aerosol inhaler for R67 was observed to be open, but not dated as to when it had been put into use. At 10:41 a.m., LPN-A verified medications should be labeled and stored properly. LPN-A stated she would remove the inhaler and replace it with a new inhaler from the medication storage room. During observations with registered nurse (RN)-A of the medication storage cart on the transitional care unit (TCU)on the first floor, on 4/11/18 at 10:44 a.m., two Advair Diskus Aerosol inhalers for R58 were observed to be opened for use, but were undated as to when opened. At 10:47 a.m., RN-A verified medications should be labeled and	21620		

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21620	Continued From page 28 stored properly and stated she would remove the undated inhalers from the medication cart and update the director of nursing (DON). During observations with RN-B of the lower level TCU cart on 4/11/18 at 11:07 a.m., a Novolog insulin flexpen was observed to be opened, and it was dated 3/8/18. However, there was no label on the insulin pen. RN-B stated it was R118's Novolog flexpen, but verified the insulin pen lacked an appropriate label. RN-B stated she would remove the insulin pen from use and replace it with another insulin flex pen from the medication room refrigerator. During interview with the DON on 4/11/18 at 1:07 p.m., the DON stated she would ensure concerns about the medications identified would 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	21620		

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21620	Continued From page 29 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." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.	21830		5/21/18

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21830	Continued From page 30 (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required 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 notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not	21830		

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21830	Continued From page 31 liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R128) reviewed for choices had the opportunity to bathe more than once a week.	21830	Corrected	

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21830	Continued From page 32 Findings include: R128 was admitted to the facility on 8/29/17, and according to the minimum data set (MDS) assessment dated 3/19/18, was assessed to be cognitively impaired (brief interview for mental status score of 5). R128 was interviewed alongside a family member (F)-E. During interview on 4/9/18, at 6:22 p.m., F-E was asked about the ability for R128 to make choices that were important to the resident. When asked about bathing choices, F-E said R128 was not offered a choice of bathing frequency. F-E said when R128 was admitted, staff informed the resident all residents had an assigned weekly shower day. F-E said R128 was not offered an extra shower, as all residents had an assigned weekly shower. When asked about R128's past preferences, F-E said that R128 used to take two or more showers each week. F-E expressed a desire for R128 to be able to have at least two showers a week while at the facility. Review of the facility's assessment, Interview for Daily and Activity Preferences dated 9/1/17, revealed a section titled, Interview for Daily Preferences. According to the assessment, the resident was asked, "While you are in this facility how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?" R128's response was documented as, "Very Important." The assessment did not include a question about frequency of bathing. During interview on 4/12/18, at 2:11 p.m., licensed practical nurse (LPN)-C was asked about the process for assessing residents' bathing preferences. LPN-C said the nurses completed initial admission assessments for newly admitted residents. LPN-C was unsure	21830		

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21830	Continued From page 33 whether the admission assessment asked about the residents' preferences for frequency of bathing. LPN-C verified each resident's shower day was based on the resident's room number and said if someone specifically requested another shower, staff would accommodate that, but explained that the shower schedule was assigned initially by room number in order to ensure care staff were not overwhelmed by the number of showers to be completed in a day. During interview on 4/12/18, at 2:56 p.m., registered nurse (RN)-F was asked about the process for assigning one shower a week based on a resident's room number. RN-F acknowledged assigning residents a weekly shower schedule based solely on room number did not seem to be very individualized. A policy regarding assessment of bathing preferences was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop policies and procedures to ensure residents' choices regarding care and routines are honored. The DON or designee could educate all appropriate staff on these policies and procedures and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		