#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

|  |   |  |  | AND TRANSMITTAL         ID: T2F1           XTE SURVEY AGENCY         Facility ID: 00803 |   |  | ID: T2F1<br>Facility ID: 00803   |  |  |
|--|---|--|--|---|---|--|--|--|--|
| MEDICARE/MEDICAID PROVIDER NO.     (L1) 245235     2.STATE VENDOR OR MEDICAID NO.     (L2) 662675000     5. EFFECTIVE DATE CHANGE OF OWNERS     (L9) 05/01/2007              |   | <ol> <li>NAME AND ADI</li> <li>(L3) WOODBURY</li> <li>(L4) 7012 LAKE F</li> <li>(L5) WOODBURY</li> <li>PROVIDER/SUP</li> </ol> | DRESS OF FACILIT<br>7 <b>HEALTH CAR</b><br>ROAD<br>7, MN<br>PLIER CATEGORY | Y<br>E CENTER   | (L6) <b>55</b>  | 5125                                   | <ol> <li>TYPE OF ACTION</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> <li>On-Site Visit</li> <li>Full Survey After</li> </ol> | N: <u>7 (</u> L8)<br>2. Recertification<br>4. CHOW<br>6. Complaint<br>9. Other |  |
| (L9)       05/01/2007         6.       DATE OF SURVEY       03/23/2010         8.       ACCREDITATION STATUS:         0 Unaccredited       1 TJC         2 AOA       3 Other | 6 (L34)<br>(L10)  | 01 Hospital<br>02 SNF/NF/Dual<br>03 SNF/NF/Distinct<br>04 SNF  | 05 HHA<br>06 PRTF<br>07 X-Ray<br>08 OPT/SP                                 | 09 ESRD<br>10 NF<br>11 ICF/IID<br>12 RHC  | 13 PTIP<br>14 CORF<br>15 ASC<br>16 HOSPICE  | 22 CLIA                                | FISCAL YEAR ENDIN<br>09/30   | IG DATE: (L35)   |  |
| 11LTC PERIOD OF CERTIFICATION<br>From (a) :<br>To (b) :<br>12.Total Facility Beds  | <b>175</b> (L18)  | 10.THE FACILITY I<br>X A. In Complian<br>Program Rec<br>Compliance<br>1. A   | ce With<br>quirements  |   | 2. Technic<br>3. 24 Houn<br>4. 7-Day F  | al Personnel<br>r RN<br>RN (Rural SNF) | Following Requirements:<br>6. Scope of Se<br>7. Medical Dir<br>8. Patient Roor   | rvices Limit<br>rector   |  |
| 13.Total Certified Beds  | 175 (L17)   | -  | oliance with Program   |   | 5. Life Saf<br>* Code: A <sup>3</sup><br>15. FACILITY MEE   | *                                      | 9. Beds/Room<br>(L12)  |  |  |
| 18 SNF 18/19 SNF<br>175<br>(L37) (L38)   | 19 SNF<br>(L39)   | ICF<br>(L42)   | IID<br>(L43)   |   | 1861 (e) (1) or 186   |  | (L15)  |  |  |
| 16. STATE SURVEY AGENCY REMARKS (IF  | 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): |  |  |   |   |  |  |  |  |
| 17. SURVEYOR SIGNATURE   |   | Date :   |  |   | 18. STATE SURVEY  | Y AGENCY APP                           | PROVAL   | Date:  |  |
| Cynthia Wentkiewicz,   | HFE NE  | II (   | 03/23/2016   | (L19)   | Kate Johns  | sTon, Pro                              | ogram Special  | ist 04/15/2016 (L20)   |  |
| P  | ART II - TO   | BE COMPLETEI   | D BY HCFA RE   | GIONAL  | OFFICE OR SIN   | IGLE STAT                              | EAGENCY  |  |  |
| 19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Participation        2. Facility is not Eligible  | e<br>(L21)  |  | PLIANCE WITH CI<br>ITS ACT:  | IVIL  | <ol> <li>1. Statement of Financial Solvency (HCFA-2572)</li> <li>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>3. Both of the Above :</li> </ol> |  |  | FA-1513)   |  |
| 22. ORIGINAL DATE 23   | . LTC AGREEM  | FNT 2  | 4. LTC AGREEME   | NT  | 26. TERMINATIO  | N ACTION:                              |  | (L30)  |  |
| OF PARTICIPATION<br>06/01/1981<br>(L24)  | BEGINNING   |  | ENDING DATE<br>(L25)   |   | <u>VOLUNTARY</u><br>01-Merger, Closure<br>02-Dissatisfaction W  | 00                                     | 05-Fail to   |  |  |
| 25. LTC EXTENSION DATE: 27   | ALTERNATIV  |  | (L23)  |   | 03-Risk of Involuntar<br>04-Other Reason for <sup>1</sup>   |  | <u>OTHER</u><br>07-Provid<br>00-Active   | er Status Change   |  |
| (L27)  | B. Rescind Sus  | pension Date:  | (L45)  |   |   |  |  |  |  |
| 28. TERMINATION DATE:  | 29  | . INTERMEDIARY/C   |  |   | 30. REMARKS   |  |  |  |  |
|  | 03001   |  |  |   |   |  |  |  |  |
|  | (L28) (L31  |  |  |   |   |  |  |  |  |
| 31. RO RECEIPT OF CMS-1539   | 32  | . DETERMINATION C<br>03/10/2016  | OF APPROVAL DAT  | Е   | Posted 05/11  | 1/2016 Co.                             |  |  |  |
|  | (L32)   |  |  | (L33)   | DETERMINATI   | ON APPROV                              | VAL  |  |  |



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245235 April 15, 2016

Mr. Michael Karel, Administrator Woodbury Health Care Center 7012 Lake Road Woodbury, Minnesota 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 April 13, 2016 the above facility is certified for or recommended 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.

Woodbury Health Care Center April 15, 2016 Page 2

Sincerely,

X Suston ate

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 5, 2016

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

RE: Project Number S5235027

Dear Mr. Karel:

On February 16, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 4, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 23, 2016, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on February 4, 2016.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the February 4, 2016 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 4, 2016. (42 CFR 488.417 (b))

Woodbury Health Care Center April 5, 2016 Page 2

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 4, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 4, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Woodbury Health Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 4, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

### APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <u>https://dab.efile.hhs.gov</u> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

### Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

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

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 August 4, 2016 (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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Woodbury Health Care Center April 5, 2016 Page 4

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 444 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,

ale Compton

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 15, 2016

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

RE: Project Number F5235026

Dear Mr. Karel:

On April 5, 2016, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 4, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of April 5, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 5, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on February 4, 2016, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our April 5, 2016 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 13, 2016, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 4, 2016, as of April 13, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and

Woodbury Health Care Center April 15, 2016 Page 2

Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of April 5, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 4, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 4, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 4, 2016, is to be rescinded.

In our letter of April 5, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 4, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 13, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

ate Compton

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

## **POST-CERTIFICATION REVISIT REPORT**

|                          | MULTIPLE CONSTRUCTION |                                       | DATE OF REVISIT |    |
|--------------------------|-----------------------|---------------------------------------|-----------------|----|
| IDENTIFICATION NUMBER    | A. Building           |                                       |                 |    |
| 245235 <sub>Y1</sub>     | B. Wing               | Y2                                    | 3/23/2016       | Y3 |
| NAME OF FACILITY         |                       | STREET ADDRESS, CITY, STATE, ZIP CODE |                 |    |
| WOODBURY HEALTH CARE CEN | TER                   | 7012 LAKE ROAD                        |                 |    |
|                          |                       | WOODBURY, MN 55125                    |                 |    |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| ITE   | M                        | DATE  | ITEM            |         |                  | DATE       | ITEM      |                            |              | DATE       |
|---|--------------------------|---|-----------------|---------|------------------|------------|-----------|----------------------------|--------------|------------|
| Y4  |                          | Y5  | Y4              |         |                  | Y5         | Y4        |                            |              | Y5         |
| ID Prefix                                   | F0154                    | Correction  | ID Prefix       | F0279   |                  | Correction | ID Prefix | F0280                      |              | Correction |
| Reg. #                                      | 483.10(b)(3), 483<br>(2) | .10(d) Completed  | Reg. #          | 483.20( | d), 483.20(k)(1) | Completed  | Reg. #    | 483.20(d)(3), 483.1<br>(2) | 0(k)         | Completed  |
| LSC   |                          | 03/15/2016  | LSC             |         |                  | 03/15/2016 | LSC       |                            |              | 03/15/2016 |
| ID Prefix                                   | F0282                    | Correction  | ID Prefix       | F0312   |                  | Correction | ID Prefix | F0412                      |              | Correction |
| Reg. #                                      | 483.20(k)(3)(ii)         | Completed   | Reg. #          | 483.25( | a)(3)            | Completed  | Reg. #    | 483.55(b)                  |              | Completed  |
| LSC   |                          | 03/15/2016  | LSC             |         |                  | 03/15/2016 | LSC       |                            |              | 03/15/2016 |
| ID Prefix                                   | F0431                    | Correction  | ID Prefix       | F0441   |                  | Correction | ID Prefix | F0465                      |              | Correction |
| Reg. #                                      | 483.60(b), (d), (e)      | Completed   | Reg. #          | 483.65  |                  | Completed  | Reg. #    | 483.70(h)                  |              | Completed  |
| LSC   |                          | 03/15/2016  | LSC             |         |                  | 03/15/2016 | LSC       |                            |              | 03/15/2016 |
| ID Prefix                                   |                          | Correction  | ID Prefix       |         |                  | Correction | ID Prefix |                            |              | Correction |
| Reg. #                                      |                          | Completed   | Reg. #          |         |                  | Completed  | Reg. #    |                            |              | Completed  |
| LSC   |                          |   | LSC             |         |                  | -          | LSC       |                            |              |            |
| ID Prefix                                   |                          | Correction  | ID Prefix       |         |                  | Correction | ID Prefix |                            |              | Correction |
| Reg. #                                      |                          | Completed   | Reg. #          |         |                  | Completed  | Reg. #    |                            |              | Completed  |
| LSC   |                          |   | LSC             |         |                  | -          | LSC       |                            |              |            |
| REVIEWE                                     | / /                      | REVIEWED BY<br>(INITIALS) SR/KJ   | date<br>03/31/2 | 2016    | SIGNATURE OF SU  |            | 986       |                            | date<br>03/2 | 3/2016     |
| REVIEWE                                     | D BY                     | REVIEWED BY<br>(INITIALS)   | DATE            |         | TITLE            |            |           |                            | DATE         |            |
| FOLLOWUP TO SURVEY COMPLETED ON<br>2/4/2016 |                          | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF<br>UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |                 |         |                  |            | 6 🗌 NO    |                            |              |            |

# **POST-CERTIFICATION REVISIT REPORT**

| PROVIDER / SUPPLIER / CLIA / | MULTIPLE CONSTRUCTION             |                                       | DATE OF REVISIT |    |
|------------------------------|-----------------------------------|---------------------------------------|-----------------|----|
| IDENTIFICATION NUMBER        | A. Building 01 - MAIN BUILDING 01 |                                       |                 |    |
| 245235 <sub>Y1</sub>         | B. Wing                           | Y2                                    | 4/13/2016       | Y3 |
| NAME OF FACILITY             |                                   | STREET ADDRESS, CITY, STATE, ZIP CODE |                 |    |
| WOODBURY HEALTH CARE CEN     | TER                               | 7012 LAKE ROAD                        |                 |    |
|                              |                                   | WOODBURY, MN 55125                    |                 |    |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| ITE   | M                 | DATE                                  | ITEM                       |                          |                | DATE                                  | ITEM                       |                   |        | DATE                                  |
|---|-------------------|---------------------------------------|----------------------------|--------------------------|----------------|---------------------------------------|----------------------------|-------------------|--------|---------------------------------------|
| Y4  |                   | Y5                                    | Y4                         |                          |                | Y5                                    | Y4                         |                   |        | Y5                                    |
| ID Prefix<br>Reg. #<br>LSC  | NFPA 101<br>K0018 | Correction<br>Completed<br>04/13/2016 | ID Prefix<br>Reg. #<br>LSC | NFPA 10                  | 1              | Correction<br>Completed<br>02/22/2016 | ID Prefix<br>Reg. #<br>LSC | NFPA 101<br>K0029 |        | Correction<br>Completed<br>02/19/2016 |
| ID Prefix<br>Reg. #<br>LSC  | NFPA 101<br>K0054 | Correction<br>Completed<br>02/24/2016 | ID Prefix<br>Reg. #<br>LSC | NFPA 10                  | 1              | Correction<br>Completed<br>03/04/2016 | ID Prefix<br>Reg. #<br>LSC | NFPA 101          |        | Correction<br>Completed<br>02/05/2016 |
| ID Prefix<br>Reg. #<br>LSC  | NFPA 101          | Correction Completed 02/22/2016       | ID Prefix<br>Reg. #<br>LSC |                          |                | Correction                            | ID Prefix<br>Reg. #<br>LSC |                   |        | Correction                            |
| ID Prefix<br>Reg. #<br>LSC  |                   | Correction Completed                  | ID Prefix<br>Reg. #<br>LSC |                          |                | Correction<br>Completed               | ID Prefix<br>Reg. #<br>LSC |                   |        | Correction<br>Completed               |
| ID Prefix<br>Reg. #<br>LSC  |                   | Correction Completed                  | ID Prefix<br>Reg. #<br>LSC |                          |                | Correction<br>Completed               | ID Prefix<br>Reg. #<br>LSC |                   |        | Correction<br>Completed               |
| REVIEWED BY<br>STATE AGENCY     REVIEWED BY<br>(INITIALS)       REVIEWED BY<br>CMS RO     REVIEWED BY<br>(INITIALS)       FOLLOWUP TO SURVEY COMPLETED ON<br>2/4/2016 |                   |                                       |                            | SIGNATURE OF SU<br>TITLE | D DEFICIENCIES |                                       |                            | DATE<br>DATE      | з 🗆 NO |                                       |

#### STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / | MULTIPLE CONSTRUCTION |                                       | DATE OF REVISIT |    |
|------------------------------|-----------------------|---------------------------------------|-----------------|----|
| IDENTIFICATION NUMBER        | A. Building           |                                       |                 |    |
| 00803 <sub>Y1</sub>          | B. Wing               | Y2                                    | 3/23/2016       | Y3 |
| NAME OF FACILITY             |                       | STREET ADDRESS, CITY, STATE, ZIP CODE |                 |    |
| WOODBURY HEALTH CARE CEN     | ITER                  | 7012 LAKE ROAD                        |                 |    |
|                              |                       | WOODBURY, MN 55125                    |                 |    |

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| ITE   | М                            |   | DATE            | ITEM           |                    |                | DATE           | ITEM      |                               |               | DATE       |
|---|------------------------------|---|-----------------|----------------|--------------------|----------------|----------------|-----------|-------------------------------|---------------|------------|
| Y4  |                              |   | Y5              | Y4             |                    |                | Y5             | Y4        |                               |               | Y5         |
|   |                              |   | 0 "             |                |                    |                | 0              |           |                               |               | <b>0</b> " |
| ID Prefix                                   | 20560                        |   | Correction      | ID Prefix      | 20565              |                | Correction     | ID Prefix | 20570                         |               | Correction |
| Reg. #                                      | MN Rule 4658.04<br>Subp. 2   | 05  | Completed       | Reg. #         | MN Rule<br>Subp. 3 | e 4658.0405    | Completed      | Reg. #    | MN Rule 4658.040<br>Subp. 4   | 5             | Completed  |
| LSC   |                              |   | 03/15/2016      | LSC            |                    |                | 03/15/2016     | LSC       |                               |               | 03/15/2016 |
| ID Prefix                                   | 20920                        |   | Correction      | ID Prefix      | 21325              |                | Correction     | ID Prefix | 21375                         |               | Correction |
| Reg. #                                      | MN Rule 4658.05<br>Subp. 6 B | 25  | Completed       | Reg. #         | MN Rule<br>Subp. 1 | e 4658.0725    | Completed      | Reg. #    | MN Rule 4658.080<br>Subp. 1   | 0             | Completed  |
| LSC   |                              |   | 03/15/2016      | LSC            |                    |                | 03/15/2016     | LSC       |                               |               | 03/15/2016 |
| ID Prefix                                   | 21426                        |   | Correction      | ID Prefix      | 21620              |                | Correction     | ID Prefix | 21685                         |               | Correction |
|   | MN St. Statute 14            | 44.04   | Concolon        |                |                    | e 4658.1345    | -              |           | MN Rule 4658.141              | 5             |            |
| Reg. #                                      | Subd. 3                      | 47.04   | Completed       | Reg. #         |                    | - 4000.1040    | Completed      | Reg. #    | Subp. 2                       | 5             | Completed  |
| LSC   |                              |   | 03/15/2016      | LSC            |                    |                | 03/15/2016     | LSC       |                               |               | 03/15/2016 |
|   |                              |   |                 |                |                    |                |                |           |                               |               |            |
| ID Prefix                                   | 21695                        |   | Correction      | ID Prefix      | 21710              |                | Correction     | ID Prefix | 21825                         |               | Correction |
| Reg. #                                      | MN Rule 4658.14<br>Subp. 4   | 15  | Completed       | Reg. #         | MN Rule<br>Subp. 7 | e 4658.1415    | Completed      | Reg. #    | MN St. Statute 144<br>Subd. 9 | .651          | Completed  |
| LSC   |                              |   | 03/15/2016      | LSC            |                    |                | 03/15/2016     | LSC       |                               |               | 03/15/2016 |
| ID Prefix                                   |                              |   | Correction      | ID Prefix      |                    |                | Correction     | ID Prefix |                               |               | Correction |
| Reg. #                                      |                              |   | Completed       | Reg. #         |                    |                | Completed      | Reg. #    |                               |               | Completed  |
| LSC   |                              |   |                 | LSC            |                    |                | -              | LSC       |                               |               |            |
|   |                              |   |                 |                |                    |                |                |           |                               |               |            |
| REVIEWE<br>STATE AG                         |                              | REVIEWE<br>(INITIALS  | ы вү<br>) SR/KJ | date<br>03/31/ | 2016               | SIGNATURE OF S | JRVEYOR<br>349 | 86        |                               | date<br>03/23 | 3/2016     |
| REVIEWE<br>CMS RO                           | D BY                         | REVIEWE<br>(INITIALS  |                 | DATE           |                    | TITLE          |                | DATE      |                               |               |            |
| FOLLOWUP TO SURVEY COMPLETED ON<br>2/4/2016 |                              | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF<br>UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |                 |                |                    |                |                | s 🗌 no    |                               |               |            |

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

|  |  |   |  |                               | ND TRANSMITTAL<br>E SURVEY AGENCY  |  | ID: T2F1<br>Facility ID: 00803  |
|--|--|---|--|-------------------------------|--|--|---|
| 1. MEDICARE/MEDICAID PROVIDER N           (L1)         245235           2.STATE VENDOR OR MEDICAID NO.         (L2)           662675000         662675000  | 0.   | 3. NAME AND ADI<br>(L3) WOODBURY<br>(L4) 7012 LAKE F<br>(L5) WOODBURY | A HEALTH CARE<br>ROAD  |                               | (L6) 55125   | 4. TYPE<br>1. Initia<br>3. Term<br>5. Valid<br>7. On-S | ination 4. CHOW<br>ation 6. Complaint   |
| <ol> <li>5. EFFECTIVE DATE CHANGE OF OWN<br/>(L9) 05/01/2007</li> </ol>  | NERSHIP  | 7. PROVIDER/SUP<br>01 Hospital  | PLIER CATEGORY<br>05 HHA   | 09 ESRD                       | <u>02</u> (L7)<br>13 PTIP 22 CLIA  | 8 Full S   | Survey After Complaint  |
| 6. DATE OF SURVEY 02/04.<br>8. ACCREDITATION STATUS:<br>0 Unaccredited 1 TJC<br>2 AOA 3 Other  | /2016 (L34)<br>(L10)   | 02 SNF/NF/Dual<br>03 SNF/NF/Distinct<br>04 SNF                        | 05 HHA<br>06 PRTF<br>07 X-Ray<br>08 OPT/SP   | 10 NF<br>11 ICF/IID<br>12 RHC | 14 CORF<br>15 ASC<br>16 HOSPICE  | FISCAL YE  | EAR ENDING DATE: (L35)<br>09/30   |
| 11. LTC PERIOD OF CERTIFICATION         From       (a) :         To       (b) :         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF       18/19 SNF         175         (L37)       (L38)         16. STATE SURVEY AGENCY REMARK | 175 (L18)<br>175 (L17)<br>19 SNF<br>(L39)<br>25 (IF APPLICABLE S                   | X B. Not in Comp<br>Requirements a<br>ICF<br>(L42)                    | ice With<br>juirements<br>Based On:<br>cceptable POC<br>bliance with Program<br>ind/or Applied Waive<br>IID<br>(L43) | rs:                           | And/Or Approved Waivers 2. Technical Perso 3. 24 Hour RN 4. 7-Day RN (Rura 5. Life Safety Cod * Code: <b>B</b> * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1) | nnel6.<br>7.<br>al SNF)8.<br>[e9.<br>(L12)             | <u>uirements:</u><br>Scope of Services Limit<br>Medical Director<br>Patient Room Size<br>Beds/Room<br>(L15) |
| 17. SURVEYOR SIGNATURE   | 7 HFE NE I   | Date :  | 03/02/2016   |                               | 18. STATE SURVEY AGEN  |  | Date:   |
|  | -  |   | D BY HCFA RE   | (L19)<br>GIONAL               | OFFICE OR SINGLE   |  | (L20)   |
| 19. DETERMINATION OF ELIGIBILITY          1. Facility is Eligible to Part          2. Facility is not Eligible   |  | 20. COM   | PLIANCE WITH CI  |                               | 21. 1. Statement of  | Financial Solvency (HC<br>Control Interest Disclosu    | CFA-2572)   |
| 22. ORIGINAL DATE<br>OF PARTICIPATION<br>06/01/1981<br>(L24)   | 23. LTC AGREEMI<br>BEGINNING<br>(L41)  |   | 4. LTC AGREEMEN<br>ENDING DATE<br>(L25)  | νT                            | 26. TERMINATION ACTION<br><u>VOLUNTARY</u><br>01-Merger, Closure<br>02-Dissatisfaction W/ Reimb<br>03-Risk of Involuntary Termir                                 | _00_   | (L30)<br><u>INVOLUNTARY</u><br>05-Fail to Meet Health/Safety<br>06-Fail to Meet Agreement                   |
| 25. LTC EXTENSION DATE:<br>(L27)   | <ol> <li>ALTERNATIVI</li> <li>A. Suspension of</li> <li>B. Rescind Susp</li> </ol> | of Admissions:  | (L44)<br>(L45)   |                               | 04-Other Reason for Withdrav   |  | OTHER<br>07-Provider Status Change<br>00-Active   |
| 28. TERMINATION DATE:  | 29<br>(L28)  | . INTERMEDIARY/C.<br>03001  | ARRIER NO.   | (L31)                         | 30. REMARKS  |  |   |
| 31. RO RECEIPT OF CMS-1539   | 32   | . DETERMINATION C   | OF APPROVAL DAT  | E                             | Posted 03/10/2016 Co   | 0.   |   |
|  | (L32)  |   |  | (L33)                         | DETERMINATION A  | PPROVAL  |   |

## MDH Minnesota Department *of* Health PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 16, 2016

Mr. Allan Barr, Administrator Woodbury Health Care Center 7012 Lake Road Woodbury, Minnesota 55125

RE: Project Number S5235027

Dear Mr. Barr:

On February 4, 2016, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

### DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Minnesota Department of Health Licensing and Certification Program Health Regulation Division P.O. Box 64900 85 East Seventh Place, Suite 220 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-3793 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 March 15, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 15, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

### 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.

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

Woodbury Health Care Center February 16, 2016 Page 4

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 May 4, 2016 (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

Woodbury Health Care Center February 16, 2016 Page 5

that your provider agreement be terminated by August 4, 2016 (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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

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, Supervisor Health Care Fire Inspections State Fire Marshal Division Email: <u>tom.linhoff@state.mn.us</u> Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Late Comston

Woodbury Health Care Center February 16, 2016 Page 6

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure

cc: Licensing and Certification File

| DEPART                   | MENT OF HEALTH  | AND HUMAN SERVICES  |                     |   | APPROVED                   |
|--------------------------|---|---|---------------------|---|----------------------------|
| CENTER                   | RS FOR MEDICARE   | & MEDICAID SERVICES   |                     | OMB NC  | 0. 0938-0391               |
|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |   | TE SURVEY<br>MPLETED       |
|                          |   | 245235  | B. WING _           | 02  | 2/04/2016                  |
| NAME OF F                | PROVIDER OR SUPPLIER  | -   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                            |
| WOODB                    | URY HEALTH CARE (   | CENTER  |                     | 7012 LAKE ROAD<br>WOODBURY, MN 55125  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENT   | ſS  | F 00                | o   |                            |
|                          | as your allegation of<br>Department's accept  | of correction (POC) will serve<br>of compliance upon the<br>otance. Your signature at the<br>bage of the CMS-2567 form will<br>tion of compliance.  |                     |   |                            |
| F 154<br>SS=D            | revisit of your facilit<br>validate that substa<br>regulations has bee<br>your verification.<br>483.10(b)(3), 483.1   | acceptable POC an on-site<br>y may be conducted to<br>intial compliance with the<br>en attained in accordance with<br>0(d)(2) INFORMED OF<br>CARE, & TREATMENTS   | F 15                | 4   | 3/15/16                    |
|                          | The resident has th<br>language that he or  | e right to be fully informed in<br>she can understand of his or<br>us, including but not limited to,  |                     |   |                            |
|                          | advance about care  | e right to be fully informed in<br>and treatment and of any<br>e or treatment that may affect<br>being.   |                     |   |                            |
| LABORATOR                | by:<br>Based on interview<br>facility failed to obta<br>R161's family decis<br>initiation of occupat<br>resident reviewed for<br>Findings include:<br>Review of R161's n<br>data set (MDS), dat | NT is not met as evidenced<br>v and document review, the<br>ain informed consent from<br>ion makers, (F)-A, prior to the<br>ional therapy for 1 of 1<br>or informed consent, (R161).<br>nost recent annual minimum<br>ted 10/21/15, revealed R161 | JATURE              | F154<br>The preparation of the following plan of<br>correction of this deficiency does not<br>constitute and should not be interpreted<br>as an admission nor an agreement by the<br>facility of the truth of the facts alleged on<br>conclusions set forth in the statement of<br>deficiencies. The plan of correction<br>prepared for this deficiency was executed<br>solely because it is required by provisions | I                          |
|                          | ically Signed   | 0000  |                     |   | 02/25/2016                 |

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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.

PRINTED: 03/02/2016

|                          |   | AND HUMAN SERVICES<br><u>&amp; MEDICAID SERVICES</u>  |                     |  |   | APPROVEI<br>0938-039       |
|--------------------------|---|---|---------------------|--|---|----------------------------|
|                          | F OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION<br>NG  |   | E SURVEY<br>PLETED         |
|                          |   | 245235  | B. WING _           |  | 02/   | 04/2016                    |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |                            |
| WOODB                    | URY HEALTH CARE C   | ENTER   |                     | 7012 LAKE ROAD<br>WOODBURY, MN 55125   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | LD BE   | (X5)<br>COMPLETION<br>DATE |
| F 154                    | was significantly co<br>During interview on<br>reported he was a co<br>health and financial<br>reported he receive<br>form which indicate<br>occupational therap<br>November. F-A there<br>would get similar st<br>January. F-A report<br>was receiving occup<br>told by the facility to<br>that it was ending a<br>stating R161 would<br>November . F-A rep<br>getting new silverwa<br>the extent of service<br>it would be several<br>November, Decemb<br>he would want to be<br>any rehabilitation se<br>had told the facility<br>occurred about a ye<br>needed rehabilitation<br>have it, but he want<br>make that determin<br>On 2/3/16, at 12:48<br>rehabilitation therap<br>just informed after F<br>or so ago that F-A f<br>not being fully inform<br>OT. DRT reported F<br>improve self feeding<br>December and Jan<br>rehabilitation therap<br>informed consent for | gnitively impaired.<br>2/1/16, at 7:04 p.m., F-A<br>designated decision maker for<br>matters for R161. F-A<br>d an explanation of benefit<br>d he owed over \$90 for<br>by (OT) for the month of<br>n reported he found out he<br>atements for December and<br>ed he was not aware R161<br>pational therapy until he was<br>o come down and sign a form<br>nd received a form in the mail<br>owe over \$90 for OT in<br>borted he had heard R161 was<br>are from OT, but had no idea<br>es R161 was receiving or that<br>sessions of OT during<br>ber and January. F-A reported<br>e fully informed in advance of<br>ervices prior to initiation and<br>this after a similar incident<br>ear prior. F-A reported if R161<br>on therapy, he wanted her to<br>red enough information to | F 15                | <ul> <li>of State of Law. Without waiving a forgoing statement, the facility state.</li> <li>1. With respect to resident #161, resident decision maker has been informed of the Occupational The services provided. Facility has off refund costs incurred to the famil 2. All residents currently receiving therapies have been reviewed to informed consents have been conwith appropriate decision maker.</li> <li>3. All licensed staff receiving physoorders for rehab therapies will no resident decision maker of new or and rationale. All licensed nursing be re-educated by March 15, 201 regarding the process for notificate when receiving new orders.</li> <li>4. The Director of Nursing and/or designee will audit 3 therapy refere ach week for one month and two referrals each week for two mont assure informed consent has beer received on new therapy orders as new orders for therapy service been obtained.</li> <li>5. The data collected will be pres QAPI by the Director of Nursing. will be reviewed/discussed and decision/recommendations mader regarding any necessary follow u studies.</li> </ul> | ates that:<br>the<br>prapy<br>fered to<br>y.<br>g rehab<br>assure<br>mpleted<br>sician<br>tify<br>rders<br>g staff will<br>6<br>tion<br>rrals<br>o therapy<br>hs to<br>en<br>us long<br>us have<br>ented at<br>The data |                            |

If continuation sheet Page 2 of 21

|                          |   | AND HUMAN SERVICES  |                   |     |  | FORM      | 03/02/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|-------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>IPLETED                 |
|                          |   | 245235  | B. WING           |     |  | 02/       | 04/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                   |     | TREET ADDRESS, CITY, STATE, ZIP CODE   | -         |                                     |
| WOODB                    | URY HEALTH CARE C   | CENTER  |                   |     | 012 LAKE ROAD<br>VOODBURY, MN 55125  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 154                    | obtain informed cor<br>resident decision m<br>rehabilitation therap<br>had recently discus<br>learning of F-A's co<br>documented. DRT<br>rehabilitation therap<br>getting informed co<br>services. There was<br>ensure informed co<br>the start of rehabilit<br>to her knowledge, F<br>funds to pay the co-<br>OT services, even t<br>not obtained. A poli-<br>consent prior to initi<br>services was reque<br>Review of R161's a<br>2/4/16, revealed F-/<br>maker for R161's fin<br>Another family men<br>emergency contact.<br>Review of R161's C<br>Progress and Upda<br>Therapist Progress<br>dated 11/10/15 to 1,<br>received OT service<br>ability between thos<br>Review of a Concer<br>undated revealed a<br>See attached therap<br>will be more for Dec<br>when therapy is pro<br>surprise! [F-A-phon<br>Explanation of Bene | nsent from the resident or the<br>nakers prior to the start of<br>by services. DRT reported she<br>used this with her staff after<br>oncern. However, this was not<br>reported she discovered<br>by staff were not routinely<br>onsent prior to starting<br>s no formal process in place to<br>onsent was obtained prior to<br>tation services. DRT reported,<br>F-A still needed to use R161's<br>-pay of over \$90 for R161's<br>though informed consent was<br>to on obtaining informed<br>tating rehabilitation therapy<br>ested but not provided.<br>A was the primary decision<br>nancial and care decisions.<br>There was noted as an<br>t, but not a decision maker.<br>DT Plan of Care, Therapist<br>ated Plan of Care and<br>a and Discharge Summary,<br>/18/16 revealed R161<br>es to improve self feeding | F                 | 154 |  |           |                                     |

If continuation sheet Page 3 of 21

|                          |  | AND HUMAN SERVICES  |                     |   | FORM        | : 03/02/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|--|---|---------------------|---|-------------|---|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | PLE CONSTRUCTION  | (X3) DAT    | TE SURVEY<br>MPLETED                    |
|                          |  | 245235  | B. WING             |   | <b>02</b> / | /04/2016                                |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |             |   |
| WOODB                    | URY HEALTH CARE C  | ENTER   |                     | 7012 LAKE ROAD<br>WOODBURY, MN 55125  |             |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE      | (X5)<br>COMPLETION<br>DATE              |
| F 154<br>F 279<br>SS=D   | 11/23/15. R161 was<br>\$94.75 for these se<br>read "Surprise! 2 m<br>On 2/11/16, the faci<br>attachment with an<br>effective 11/10/15 u<br>noted "Treatment P<br>and alternatives dis<br>family, who agree to<br>note did not indicate<br>informed consent a<br>received. The note<br>informed consent fr<br>decision maker for<br>matters, (F)-A. The<br>was informed of the<br>benefits and alterna<br>ensure it was in a m<br>There was no docu<br>given updates on u<br>12/8/15, 12/28/15 a<br>11/10/15 and ending<br>483.20(d), 483.20(k<br>COMPREHENSIVE<br>A facility must use t<br>to develop, review a<br>comprehensive plan<br>The facility must de<br>plan for each reside<br>objectives and time<br>medical, nursing, an | s responsible for paying<br>prvices. A handwritten note<br>nonths later."<br>illity sent an email and<br>OT care plan, dated 11/10/15,<br>until 12/7/15. The OT care plan<br>Plan, including benefits, risks<br>ccussed with patient and/or<br>o treatment." However, the<br>e the individual that gave<br>and the date and time it was<br>o did not indicate OT obtained<br>from R161's designated<br>healthcare and financial<br>note did not indicate how F-A<br>e treatment plan, risks,<br>atives and what plan, risks,<br>atives were discussed to<br>nanner F-A could understand.<br>mentation indicating F-A was<br>pdated plans of care, dated<br>and 1/18/16 since initiation on<br>g 1/18/16.<br>k)(1) DEVELOP<br>E CARE PLANS<br>the results of the assessment<br>and revise the resident's | F 154               |   |             | 3/15/16                                 |

Facility ID: 00803

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|                          |  | AND HUMAN SERVICES   |                     |  | FORM   | 03/02/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|--|--|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | TIPLE CONSTRUCTION   |  | E SURVEY<br>IPLETED                 |
|                          |  | 245235   | B. WING             |  | - 02/  | 04/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STAT   |  |                                     |
| WOODB                    | URY HEALTH CARE (  | CENTER   |                     | 7012 LAKE ROAD<br>WOODBURY, MN 55125   |  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | X (EACH CORRECTIVE<br>CROSS-REFERENCED   | N OF CORRECTION<br>ACTION SHOULD BE<br>TO THE APPROPRIATE<br>IENCY)  | (X5)<br>COMPLETION<br>DATE          |
| F 279                    | to be furnished to a<br>highest practicable<br>psychosocial well-b<br>§483.25; and any s<br>be required under §<br>due to the resident'<br>§483.10, including<br>under §483.10(b)(4<br>This REQUIREMEN<br>by:<br>Based on observar<br>review, the facility f<br>of hand contracture<br>residents reviewed<br>Findings include:<br>R181's most recent<br>data set [MDS], a s<br>completed on 9/16/<br>functional impairme<br>in both upper extre<br>MDS revealed no fit<br>of motion in the upp<br>MDS revealed no fit<br>of motion in the upp<br>MDS revealed R18<br>memory problems<br>decision making ab<br>On 2/2/16, at 11:19<br>manager, (RN)-B, r<br>contracture in her h<br>range of motion set<br>device in place.<br>On 2/3/16, at 1:43 p | t describe the services that are<br>tittain or maintain the resident's<br>physical, mental, and<br>being as required under<br>ervices that would otherwise<br>\$483.25 but are not provided<br>s exercise of rights under<br>the right to refuse treatment<br>the right to refuse treatment<br>alled to identify the presence<br>es in the care plan for 1 of 2<br>for range of motion, (R181).<br>t comprehensive minimum<br>ignificant change assessment<br>(15, revealed R181 had<br>ent in range of motion (ROM)<br>mities. The 12/9/15, quarterly<br>unctional impairment in range<br>per extremities. The 12/9/15,<br>1 had short and long term<br>and significant impairment in | F 2                 | <ul> <li>The preparation of the correction of this deficiencies. The plan is an admission nor facility of the truth of conclusions set forth deficiencies. The plan prepared for this defit solely because it is reformed for the solely because it is reformed fore</li></ul> | iciency does not<br>a not be interpreted<br>an agreement by the<br>the facts alleged on<br>in the statement of<br>n of correction<br>ciency was executed<br>equired by provisions<br>out waiving the<br>he facility states that:<br>sident R181 the care<br>arding the resident's<br>erventions as<br>contractures will have<br>ewed to assure the<br>een addressed along<br>intervention.<br>g staff will be<br>h 15, 2016 regarding<br>hs when a change of<br>arsing and/or<br>resident care plans |                                     |

Facility ID: 00803

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PRINTED: 03/02/2016 FORM APPROVED

| TATEMENT                 | OF DEFICIENCIES  | MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIP         | LE CONSTRUCTION  | (X3) DAT                    | 0938-039                  |
|--------------------------|--|---|---------------------|--|-----------------------------|---------------------------|
| ND PLAN C                | F CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING         | à  | COM                         | PLETED                    |
|                          |  | 245235  | B. WING             |  | 02/04/2016                  |                           |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                             |                           |
| WOODB                    | URY HEALTH CARE  | CENTER  |                     | 7012 LAKE ROAD<br>WOODBURY, MN 55125   |                             |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | D BE                        | (X5)<br>COMPLETIO<br>DATE |
| F 279                    | contracted with fing<br>said "ouch" and RN<br>uncurl R181's hand<br>On 2/3/16, at 1:43<br>was responsible for<br>care plan reviewed<br>R181's contracture<br>reported it was det<br>benefit from range<br>device due to it not<br>her significantly at<br>almost all cares for<br>developed the cont<br>the facility. RN-B a<br>any documentation<br>to the facility's inter<br>making process to<br>splint services for F<br>appropriate goals a<br>R181's left hand co<br>was unsure if the n<br>dated 12/9/15, sho<br>functional impairme | I R181's left hand, which was<br>gers in toward the palm. R181<br>N-B stopped attempting to<br>d.<br>p.m. RN-B and RN-C, who<br>r completion of the MDS and<br>I R181's care plan and reported<br>es were not addressed. RN-B<br>ermined R181 would not<br>of motion services or a splint<br>t causing her pain or impairing<br>this point since staff provided<br>r R181. RN-B reported R181<br>tracture in August after a fall at<br>nd RN-C were unable to find<br>n in the medical record related<br>rdisciplinary team decision<br>not pursue range of motion or<br>R181 and what were<br>and interventions related to<br>ontracture. RN-C reported she<br>nost recent quarterly MDS,<br>uld have indicated no | F 279               | resident care plans a week for two<br>to assure care plans are accurate<br>reflect resident conditions.<br>5. The data collected will be prese<br>QAPI by the Director of Nursing. T<br>will be reviewed/discussed and<br>decision/recommendations made<br>regarding any necessary follow up<br>studies. | and<br>ented at<br>The data |                           |
|                          | 12/15/15, revealed<br>contracture was ac<br>The Care Plan Cor<br>8/2013 directed sta   | no indication R181's left hand<br>ddressed in the plan of care<br>npletion Policy, last revised<br>aff to include "Functional   |                     |  |                             |                           |
| F 280<br>SS=D            | Limitations in ROM<br>483.20(d)(3), 483.1<br>PARTICIPATE PLA   | •   | F 280               |  |                             | 3/15/16                   |
|                          | The resident has the incompetent or oth  | ne right, unless adjudged<br>erwise found to be   |                     |  |                             |                           |

If continuation sheet Page 6 of 21

| STATEMENT                | OF DEFICIENCIES  | E & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION   | (X3) DATE              | 0938-039<br>SURVEY<br>PLETED |
|--------------------------|--|--|---------------------|--|------------------------|------------------------------|
|                          |  |  |                     |  | 00Mil                  |                              |
|                          |  | 245235   | B. WING             |  | 02/04/2016             |                              |
| NAME OF                  | PROVIDER OR SUPPLIEF   | 1  |                     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                        |                              |
| WOODB                    | URY HEALTH CARE  | CENTER   |                     | 012 LAKE ROAD<br>VOODBURY, MN 55125  |                        |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | BE                     | (X5)<br>COMPLETIO<br>DATE    |
| F 280                    | Continued From p   | age 6  | F 280               |  |                        |                              |
|                          | incapacitated under  | er the laws of the State, to<br>ning care and treatment or   |                     |  |                        |                              |
|                          | within 7 days after<br>comprehensive as<br>interdisciplinary te<br>physician, a regist<br>for the resident, ar<br>disciplines as dete<br>and, to the extent<br>the resident, the re<br>legal representativ | care plan must be developed<br>the completion of the<br>sessment; prepared by an<br>am, that includes the attending<br>ered nurse with responsibility<br>nd other appropriate staff in<br>ermined by the resident's needs,<br>practicable, the participation of<br>esident's family or the resident's<br>re; and periodically reviewed<br>eam of qualified persons after |                     |  |                        |                              |
|                          | by:<br>Based on observa<br>review, the facility  | ENT is not met as evidenced<br>ation, interview and record<br>failed to ensure the care plan<br>of 3 residents (R105) with a<br>otion.   |                     | The preparation of the following pl<br>correction of this deficiency does n<br>constitute and should not be interpl<br>as an admission nor an agreement      | ot<br>reted            |                              |
|                          | Findings include:  |  |                     | facility of the truth of the facts alleg<br>conclusions set forth in the stateme<br>deficiencies. The plan of correction                                     | ent of                 |                              |
|                          | sitting in a Broda of<br>clenched together<br>devices were note  | a.m. R105 was observed<br>chair with both hands lightly<br>in a fist. No splints or other<br>d in the resident's hands or  |                     | prepared for this deficiency was ex<br>solely because it is required by pro<br>of State of Law. Without waiving th<br>forgoing statement, the facility state | ecuted<br>visions<br>e |                              |
|                          | observed holding a<br>independently dra<br>also observed to u  | , at 8:26 a.m. R105 was<br>a glass in the right hand and<br>nk from the glass. R105 was<br>use the left hand, pointer finger<br>However, R105 did not entirely   |                     | 1. With respect to R105, the care p<br>was revised regarding the residents<br>limited ROM and interventions as<br>indicated.                                 |                        |                              |

| STATEMENT                | OF DEFICIENCIES  | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION   | (X3) DAT   | . 0938-039<br>E SURVEY<br>IPLETED |  |
|--------------------------|--|--|---------------------|--|--|-----------------------------------|--|
|                          |  |  | A. BUILDIN          | G  |  |                                   |  |
|                          |  | 245235   | B. WING _           |  |  | 04/2016                           |  |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, Z   | IP CODE  |                                   |  |
| WOODB                    | URY HEALTH CARE  | CENTER   |                     | 7012 LAKE ROAD<br>WOODBURY, MN 55125   |  |                                   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC  | TION SHOULD BE<br>THE APPROPRIATE  | (X5)<br>COMPLETIC<br>DATE         |  |
| F 280                    | R105's left hand.<br>On 2/2/16, at 9:14<br>stated the facility h<br>in the past and R10<br>away.<br>On 2/3/16, at 3:32<br>put cloths in R105's<br>this time there were<br>and was asked abore<br>R105's left hand. F<br>hospice at one time<br>want ROM or anyth<br>pain; and ROM to R<br>On 2/4/16, at 8:57<br>stated R105 would<br>hands, and did not<br>hands were washe<br>ROM to the left han<br>allow it. NA-Z state<br>to remain in the ha<br>R105 would remov<br>The most recent ca<br>4/11/14, indicated R<br>tight, didn't extend<br>purposefully; had re<br>(OT) services; refu<br>caused increased a<br>were to complete re<br>which according to<br>provided on 1/17/12<br>When the care plan | a.m. registered nurse (RN)-B<br>as tried hand splints for R105<br>05 would remove them right<br>p.m. RN-B stated staff would<br>s hands. RN-B was informed at<br>e no cloths in R105's hands,<br>but range of motion (ROM) to<br>RN-B stated R105 had been on<br>e and the hospice staff did not<br>hing which would cause R105<br>R105's hand was "very painful."<br>a.m. nursing assistant (NA)-Z<br>allow staff to wash R105's<br>complain of pain when the<br>d. NA-Z stated that gentle<br>nd during cares if R105 would<br>de R105 would not allow a cloth<br>nd, as staff had tried that and<br>the cloth.<br>are plan dated/revised on<br>R105 would hold both hands<br>all digits consistently or<br>eceived occupational therapy<br>sed to wear splints, as they<br>agitation; and nursing staff<br>ecommendations from OT,<br>the care plan had been<br>4.<br>n was reviewed with RN-B on<br>. and RN-B was asked why the | F 28                | <ul> <li>there care plans reviewed contractures have been with the appropriate inte</li> <li>3. All licensed staff will b March 15, 2016 regardin care plans with any char orders.</li> <li>4. The Director of Nursin designee will audit 5 res each week for one mont care plans each week for assure care plans have reflect any resident char</li> <li>5. The data collected wil QAPI by the Director of will be reviewed/discuss decision/recommendation regarding any necessary studies.</li> </ul> | addressed along<br>rvention.<br>be re-educated by<br>ng revisions to<br>nge in status and<br>ng and/or<br>ident care plans<br>h and 3 resident<br>or 2 months to<br>been revised to<br>nges.<br>I be presented at<br>Nursing. The data<br>ed and<br>ons made |                                   |  |

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|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | OME PLE CONSTRUCTION (X G   | (X3) DATE SURVEY<br>COMPLETED<br>02/04/2016 |  |
|--------------------------|---|---|---------------------|---|---|--|
|                          |   | 245235  | B. WING             |   |   |  |
| NAME OF                  | PROVIDER OR SUPPLIER  | L   | 1                   | STREET ADDRESS, CITY, STATE, ZIP CODE   | 02/01/2010                                  |  |
| WOODB                    | URY HEALTH CARE (   | CENTER  |                     | 7012 LAKE ROAD<br>WOODBURY, MN 55125  |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |   |  |
| F 280<br>F 282<br>SS=D   | the cloths out. RN-I<br>had indicated ROM<br>The hospice care p<br>reviewed and indica<br>done to all extremit<br>which had a fractur<br>The facility's policy<br>and revised 8/13, ir<br>was to be updated/<br>483.20(k)(3)(ii) SEF<br>PERSONS/PER C/<br>The services provide                    | B stated the hospice care plan<br>was not to be completed.<br>lan dated 12/8/14, was<br>ated passive ROM was to be<br>ies, except the right arm,<br>ed ulna.<br>titled Care Plan Completion<br>ndicated a resident's care plan<br>revised as changes occur.<br>RVICES BY QUALIFIED  | F 28<br>F 28        |   | 3/15/16                                     |  |
|                          | by:<br>Based on observative<br>review, the facility f<br>the provision of act<br>residents (R105) de<br>completion of ADL's<br>Findings include:<br>The care plan revision<br>had cognitive loss,<br>judgement, decision<br>processes. The care<br>could be resistive w<br>staff to assist with o | NT is not met as evidenced<br>tion, interview and document<br>ailed to follow the care plan for<br>ivities of daily living for 1 of 3<br>ependent on staff for<br>s.<br>ed on 4/11/14, revealed R105<br>with deficits in memory,<br>n making, and thought<br>re plan directed staff R105<br>vith cares and required one<br>completing grooming needs.<br>iot indicate R105 did not mind |                     | The preparation of the following plan<br>correction of this deficiency does not<br>constitute and should not be interpret<br>as an admission nor an agreement by<br>facility of the truth of the facts alleged<br>conclusions set forth in the statement<br>deficiencies. The plan of correction<br>prepared for this deficiency was exec<br>solely because it is required by provis<br>of State of Law. Without waiving the<br>forgoing statement, the facility states<br>1. With respect to R105, the Nurse<br>Manager is working with the staff to<br>develop a routine for shaving the resid<br>re-approaching or obtaining the | ed<br>on<br>of<br>uted<br>ions<br>that:     |  |

Facility ID: 00803

If continuation sheet Page 9 of 21

| STATEMENT                |  | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                  |                     |   | OATE SURVEY               |
|--------------------------|--|---|---------------------|---|---------------------------|
|                          |  | 245235  |                     |   | )2/04/2016                |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                           |
| WOODB                    | URY HEALTH CARE C  | ENTER   |                     | 7012 LAKE ROAD<br>WOODBURY, MN 55125  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETIO<br>DATE |
| F 282                    | Continued From pa  | ge 9  | F 282               |   |                           |
|                          | inch long hairs were<br>and corners of the r<br>still present on 2/2/<br>8:26 a.m.; and on 2<br>On 2/4/16, at 8:59 a<br>stated R105 had a l<br>but NA-Z had not gi<br>NA-Z stated R105 h<br>assignment list for 2<br>attempted to remov<br>dates. NA-Z stated<br>shaved but would tr<br>today if the resident<br>the presence of the<br>The facility's policy<br>Program, dated 4/1<br>maintenance progra<br>assist to maintain a<br>level of function and | a.m. nursing assistant (NA)-Z<br>bath on Saturday evenings,<br>ven R105 a bath that evening.  |                     | <ul> <li>assistance of the nurse when resident refuses. The resident care plan and nursing assistant assignment sheet hav been updated accordingly.</li> <li>2. All residents have been reviewed for refusal of shaving and a plan of care established for approaches to promote a routine for shaving that best meets the residents needs. The NAR assignment sheet and resident care plan have been revised as indicated.</li> <li>3. All nursing staff will receive education by March 15, 2016 regarding managing challenges during grooming and interventions/approaches to ensure eac individuals needs are met.</li> <li>4. The Director of Nursing and/or designee will complete 5 resident audits each week for two months to assure care of the individual resident is being completed according to the individual plan of care.</li> <li>5. The data collected will be presented a QAPI by the Director of Nursing. The dat will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.</li> </ul> | a<br>h<br>t               |
| F 312<br>SS=D            | 483.25(a)(3) ADL C<br>DEPENDENT RES  | ARE PROVIDED FOR<br>IDENTS  | F 312               |   | 3/15/16                   |
|                          | daily living receives  | hable to carry out activities of<br>the necessary services to<br>tion, grooming, and personal |                     |   |                           |

Facility ID: 00803

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|                          |   | AND HUMAN SERVICES   |                     |    |  | FORM  | 03/02/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|---------------------|----|--|---|-------------------------------------|
|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |    | E CONSTRUCTION   |   | E SURVEY<br>PLETED                  |
|                          |   | 245235   | B. WING             |    |  | 02/   | 04/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                     |    | TREET ADDRESS, CITY, STATE, ZIP CODE   | -   |                                     |
| WOODB                    | URY HEALTH CARE (   | CENTER   |                     |    | 012 LAKE ROAD<br>VOODBURY, MN 55125  |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | x  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE          |
| F 312                    | Continued From pa   | ige 10   | F 3                 | 12 |  |   |                                     |
|                          | by:<br>Based on observat<br>review, the facility f<br>grooming to 1 of 3 o<br>on staff for complet<br>(ADL.)<br>Findings include:<br>On 2/1/16, at 5:45 p<br>inch long hairs were<br>and corners of the r<br>still present on 2/2/<br>8:26 a.m.; and on 2<br>On 2/4/16, at 8:59 a<br>stated R105 had a<br>but NA-Z had not g<br>NA-Z stated R105 h<br>assignment list for 2<br>attempted to remov<br>dates. NA-Z stated<br>shaved but would th<br>today if the resident<br>the presence of the<br>On 2/3/16, at 3:40 p<br>not being able to pr<br>whether or not the f<br>On 2/3/16, at 3:47 p<br>R105's conservator<br>would bother R105<br>was unable to be in<br>The facility's policy<br>Program, dated 4/1 | a.m. nursing assistant (NA)-Z<br>bath on Saturday evenings,<br>iven R105 a bath that evening.<br>nad been on NA-Z's<br>2/3 and 2/4/16, and had not<br>ve R105's chin hairs on these<br>R105 would "fight" when<br>ry to remove the chin hairs<br>t would allow it. NA-Z verified<br>e chin hairs at this time. |                     |    | The preparation of the following pl<br>correction of this deficiency does n<br>constitute and should not be interport<br>as an admission nor an agreement<br>facility of the truth of the facts alleg<br>conclusions set forth in the statement<br>deficiencies. The plan of corrections<br>prepared for this deficiency was ex<br>solely because it is required by pro-<br>of State of Law. Without waiving the<br>forgoing statement, the facility state<br>1. With respect to R105, the Nurse<br>Manager is working with the staff to<br>develop a routine for grooming the<br>resident, re-approaching or obtaining<br>assistance of the nurse when resid<br>refuses. The resident care plan and<br>nursing assistant assignment shee<br>been updated accordingly.<br>2. All residents have been reviewed<br>refusal of grooming and a plan of con-<br>established for approaches to prom-<br>routine for shaving that best meets<br>residents needs. The NAR assignment<br>sheet and resident care plan have<br>revised as indicated.<br>3. All nursing staff will receive educt<br>by March 15, 2016 regarding mana-<br>challenges during grooming and<br>interventions/approaches to ensure<br>individuals needs are met.<br>4. The Director of Nursing and/or<br>designee will complete 5 resident are<br>audits each week for two months to | ot<br>reted<br>by the<br>ed on<br>ent of<br>ecuted<br>visions<br>e<br>es that:<br>ong the<br>ent<br>d for<br>are<br>note a<br>the<br>nent<br>been<br>ation<br>iging<br>e each<br>uudits<br>sident |                                     |

Facility ID: 00803

If continuation sheet Page 11 of 21

|                          |   | AND HUMAN SERVICES   |                   |     |   | FORM  | 03/02/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|-------------------|-----|---|---|-------------------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | E CONSTRUCTION  |   | E SURVEY<br>PLETED                  |
|                          |   | 245235   | B. WING           |     |   | 02/   | 04/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |                                     |
| WOODB                    | URY HEALTH CARE (   | CENTER   |                   |     | 012 LAKE ROAD<br>VOODBURY, MN 55125   |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)   | BE  | (X5)<br>COMPLETION<br>DATE          |
| F 312<br>F 412           | assist ot maintain a<br>level of function and   | resident's highest practicable<br>d well-being.  |                   | 312 | assure care of the individual resider<br>being completed according to the<br>individual plan of care.<br>5. The data collected will be presen<br>QAPI by the Director of Nursing. Th<br>will be reviewed/discussed and<br>decision/recommendations made<br>regarding any necessary follow up<br>studies.  | ted at  | 3/15/16                             |
| SS=D                     | SERVICES IN NFS<br>The nursing facility<br>an outside resource<br>§483.75(h) of this p<br>covered under the s<br>dental services to n<br>resident; must, if ne<br>making appointmen<br>transportation to an | must provide or obtain from<br>e, in accordance with<br>part, routine (to the extent<br>State plan); and emergency<br>neet the needs of each<br>ecessary, assist the resident in<br>hts; and by arranging for<br>id from the dentist's office; and<br>r residents with lost or             |                   | +12 |   |   | 5/13/10                             |
|                          | by:<br>Based on observat<br>review, the facility f<br>services were provi<br>on an annual basis<br>dental issues.<br>Findings include:<br>On 2/2/16, at 9:33 a<br>have several lower<br>at 8:39 a.m. R105 v | NT is not met as evidenced<br>tion, interview and document<br>ailed to ensure routine dental<br>ded to 1 of 3 residents (R105)<br>to ensure there were no<br>a.m. R105 was observed to<br>front teeth missing. On 2/3/16,<br>was observed to feed self bite<br>melet and toast. There were |                   |     | The preparation of the following pla<br>correction of this deficiency does no<br>constitute and should not be interpr<br>as an admission nor an agreement<br>facility of the truth of the facts allege<br>conclusions set forth in the stateme<br>deficiencies. The plan of correction<br>prepared for this deficiency was exe<br>solely because it is required by prov<br>of State of Law. Without waiving the<br>forgoing statement, the facility state | ot<br>eted<br>by the<br>ed on<br>nt of<br>ecuted<br>visions |                                     |

Facility ID: 00803

If continuation sheet Page 12 of 21

|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION<br>G  |  | 0938-039<br>E SURVEY<br>PLETED |
|--------------------------|--|--|---------------------|--|--|--------------------------------|
|                          |  | 245235   | B. WING             |  | 02/  | 04/2016                        |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP COL   |  |                                |
| WOODB                    | URY HEALTH CARE (  | CENTER   |                     | 7012 LAKE ROAD<br>WOODBURY, MN 55125   |  |                                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)   | HOULD BE   | (X5)<br>COMPLETIC<br>DATE      |
| F 412                    | Continued From pa  | ige 12   | F 41                | 2  |  |                                |
|                          | no problems noted  | with chewing or swallowing.  |                     | 1. With respect to R105, an o  | ral screen   |                                |
|                          | was to be referred to<br>resident would grind<br>assess/observe for<br>Another portion of to<br>9/21/15, noted R10<br>missing, staff perfo-<br>not participate, but<br>dentist as needed.<br>indicate R105 was<br>annual oral exams.<br>A dental agreement<br>dental service revea-<br>signed the form on<br>consulting dental sec<br>comprehensive and<br>There was no indice<br>conservator did not<br>dentist.<br>A review of the com | t with the facility's contract<br>aled the conservator had<br>10/11/12, which authorized the   |                     | <ul> <li>was completed and dental<br/>recommendations presented<br/>for making determination for t</li> <li>2. All resident records have be<br/>by Health Information to ensu<br/>been offered dental care/serv<br/>the past 12 months.</li> <li>3. All Health Information staff<br/>re-educated by March 15, 201<br/>the guidelines and process fo<br/>visits and other ancillary servi</li> <li>4. The Director of Nursing and<br/>designee will complete 2 resid<br/>audits each week for one mor<br/>one resident chart audit each<br/>two months to assure dental so<br/>offered and obtained as reques</li> <li>5. The data collected will be p<br/>QAPI by the Director of Nursing<br/>will be reviewed/recommendar<br/>regarding any necessary follo<br/>studies.</li> </ul> | reatment.<br>een audited<br>re they have<br>ices within<br>will be<br>6 regarding<br>r dental<br>ces.<br>d/or<br>dent chart<br>oth and then<br>week for<br>services are<br>ested.<br>resented at<br>ng. The data<br>tions made |                                |
|                          | since the dental age<br>10/11/12.<br>On 2/3/16, at 3:22 p<br>stated they would c<br>record for any docu<br>visits. By 2/4/16, at<br>able to find any doc<br>On 2/4/16, at 11:30  | p.m. registered nurse (RN)-C<br>heck the thinned medical<br>imentation regarding dental<br>1:00 p.m. RN-C had not been<br>cumentation of a dental visit.<br>a.m. health unit coordinator<br>re had been a dental |                     |  |  |                                |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245235 B. WING 02/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD WOODBURY HEALTH CARE CENTER WOODBURY, MN 55125 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 412 Continued From page 13 F 412 contracting dental service did not keep dental screenings, but provided the documentation to the facility. HUC-A stated R105 had not had any dental issues that they were aware of. On 2/4/16, at 8:59 a.m. nursing assistant (NA)-Z stated R105 was resistive with oral cares, but was not having any problems with chewing or swallowing. The facility's Dental Services policy, revised 8/13, indicated annual dental services and dental services as indicated were to be provided to residents. F 431 483.60(b), (d), (e) DRUG RECORDS, F 431 3/15/16 LABEL/STORE DRUGS & BIOLOGICALS SS=D The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 03/02/2016

|                          | -   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |   | FORM  | 03/02/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|---------------------|---|---|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | IPLE CONSTRUCTION   | (X3) DAT  | E SURVEY<br>PLETED                  |
|                          |   | 245235  | B. WING _           |   | 02/   | 04/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |   | · [                 | STREET ADDRESS, CITY, STATE, ZIP CODE   | •   |                                     |
| WOODB                    | URY HEALTH CARE (   | CENTER  |                     | 7012 LAKE ROAD<br>WOODBURY, MN 55125  |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | ) BE  | (X5)<br>COMPLETION<br>DATE          |
| F 431                    | Continued From pa   | ge 14   | F 43                | 31  |   |                                     |
|                          | permanently affixed<br>controlled drugs list<br>Comprehensive Dru<br>Control Act of 1976<br>abuse, except when<br>package drug distri   | ovide separately locked,<br>I compartments for storage of<br>red in Schedule II of the<br>ug Abuse Prevention and<br>and other drugs subject to<br>in the facility uses single unit<br>bution systems in which the<br>inimal and a missing dose can   |                     |   |   |                                     |
|                          | by:<br>Based on observative<br>review, the facility factorial<br>were stored and lateresidents (R332, Rimedication storage<br>Findings include:<br>During observations<br>storage areas through<br>for R332, R123 and<br>drops, ear drop and<br>indicate when they<br>During the medicative<br>9:10 a.m. with regist<br>transition care unit<br>multiple opened, us<br>bottles were stored<br>Observations include<br>R332's Azelastine (<br>bottle was opened, | s of multiple medication<br>ighout the facility, medications<br>d R234, which included eye<br>d insulins, lacked dates to<br>were opened.<br>ion storage tour on 2/3/16, at<br>stered nurse (RN)-A, in the<br>team 3 medication cart,<br>sed and undated medication<br>in medication carts.<br>ded the following:<br>redness of eye) eye drop<br>used and was undated.<br>or infection) ear drop bottle |                     | The preparation of the following pl<br>correction of this deficiency does n<br>constitute and should not be interp<br>as an admission nor an agreement<br>facility of the truth of the facts alleg<br>conclusions set forth in the statement<br>deficiencies. The plan of correction<br>prepared for this deficiency was ex-<br>solely because it is required by pro-<br>of State of Law. Without waiving the<br>forgoing statement, the facility stat<br>1. With respect to residents<br>R332,R123,R234; medications we<br>removed from the storage areas and<br>disposed of properly.<br>2. All medication storage areas have<br>inspected for proper compliance w<br>handling, storage and dating of op-<br>medications. All medications not in<br>compliance have been disposed of<br>according to facility protocol.<br>3. Processes have been developed<br>periodic inspection of the medication<br>storage areas for cleanliness, prop | ot<br>reted<br>t by the<br>jed on<br>ent of<br>tecuted<br>visions<br>le<br>es that:<br>re<br>nd<br>ve been<br>ith<br>ened<br>f<br>f |                                     |

Facility ID: 00803

| STATEMEN                 | OF DEFICIENCIES  | KOMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  | (X3) DAT   | 0938-039<br>E SURVEY      |  |
|--------------------------|--|--|---------------------|---|--|---------------------------|--|
|                          |  |  |                     | G   |  |                           |  |
|                          |  | 245235   | B. WING             |   |  | 04/2016                   |  |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>7012 LAKE ROAD   | DDE  |                           |  |
| WOODB                    | URY HEALTH CARE  | CENTER   |                     | WOODBURY, MN 55125  |  |                           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)   | SHOULD BE  | (X5)<br>COMPLETIO<br>DATE |  |
| F 431                    | opened, used and<br>On 2/3/16, at 9:17<br>medications neede<br>properly. RN-A ado<br>should be dated wh<br>remove from medic<br>and reorder them.<br>During the medicata<br>9:41 a.m., with LPN<br>medication storage<br>following observation<br>R234's Latanopros<br>bottle was opened,<br>On 2/3/16, at 9:41<br>medications should<br>properly. LPN-A ado<br>should be dated wh<br>and reorder new or<br>On 2/3/16, at 10:30<br>(DON) explained the<br>medication bottles<br>addition, the DON<br>follow policies and<br>Undated Medication<br>guidelines, directed<br>opened - room terr<br>use, date when ope<br>opened - room terr<br>use, date when ope<br>Policy and procedu | diabetes) insulin vial was<br>was undated.<br>a.m. RN-A verified the<br>ed to be labeled and stored<br>led that opened medications<br>nen opened and stated she will<br>cation cart, dispose of properly<br>tion administration on 2/3/16, at<br>N-A, the third floor south<br>e cart was reviewed. The<br>on was made:<br>.t (anti-glaucoma) eye drop<br>, used and was undated.<br>a.m. LPN-A verified<br>d be labeled and stored<br>lded that opened medications<br>nen opened and will remove<br>nes.<br>0 a.m. the director of nursing<br>nat staff were supposed to date<br>and vials when opened. In<br>indicated that staff should<br>pharmacy recommendations.<br>n storage and expiration<br>d, "insulin 10 ML (milliliter) vials<br>operature, 28 days after 1st<br>en yes. Xalatan eye drops<br>operature, 45 days after 1st | F 43                | 1<br>storage and disposal. All lice<br>staff/trained medication aide<br>educated regarding medicat<br>and storage guidelines by M<br>4. The Director of Nursing aid<br>designee will audit 3 medica<br>areas each week for one mo<br>medication storage areas ea<br>months to assure proper sto<br>and disposal of expired med<br>5. The data collected will be<br>QAPI by the Director of Nurs<br>will be reviewed/discussed a<br>decision/recommendations r<br>regarding any follow up stud | s will be re<br>ion expiration<br>arch 15, 2016<br>nd/or<br>tion storage<br>onth and 2<br>uch week for 2<br>rage, dating<br>ications.<br>presented in<br>sing. The data<br>ind<br>nade |                           |  |

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| TATEMEN                  | OF DEFICIENCIES   | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTI          | PLE CONSTRUCTION   | · · / | E SURVEY                  |
|--------------------------|---|--|---------------------|--|-------|---------------------------|
| ND PLAN (                | OF CORRECTION   | IDENTIFICATION NUMBER:   | A. BUILDIN          | G  | CON   | 1PLETED                   |
|                          |   | 245235   | B. WING             |  | 02/   | 04/2016                   |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |       |                           |
| WOODB                    | URY HEALTH CARE   | CENTER   |                     | 7012 LAKE ROAD<br>WOODBURY, MN 55125   |       |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE  | (X5)<br>COMPLETIC<br>DATE |
| F 431                    | on storage condition (see chart for example)  | anufacturer that are dependent<br>ons and/or date of this use.<br>nple). Nursing staff will write<br>the container label for these   | F 43                | 1  |       |                           |
| F 441<br>SS=D            | 483.65 INFECTION  | N CONTROL, PREVENT   | F 44                | 1  |       | 3/15/16                   |
|                          | Infection Control P safe, sanitary and c  | stablish and maintain an<br>rogram designed to provide a<br>comfortable environment and<br>development and transmission<br>oction.   |                     |  |       |                           |
|                          | Program under wh<br>(1) Investigates, cc<br>in the facility;<br>(2) Decides what p<br>should be applied t   | stablish an Infection Control<br>ich it -<br>ontrols, and prevents infections<br>rocedures, such as isolation,<br>to an individual resident; and<br>ord of incidents and corrective  |                     |  |       |                           |
|                          | determines that a r<br>prevent the spread<br>isolate the resident<br>(2) The facility must<br>communicable dise<br>from direct contact<br>direct contact will tr<br>(3) The facility must<br>hands after each d | tion Control Program<br>esident needs isolation to<br>of infection, the facility must<br>the prohibit employees with a<br>ease or infected skin lesions<br>with residents or their food, if<br>ransmit the disease.<br>It require staff to wash their<br>irect resident contact for which<br>dicated by accepted |                     |  |       |                           |

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|                          |  | AND HUMAN SERVICES   | _       |  |  | FORM  | 03/02/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------|--|--|---|-------------------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |         | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |   | E SURVEY<br>PLETED                  |
|                          | 245235   |  | B. WING |  |  | 02/0  | 04/2016                             |
| NAME OF I                | NAME OF PROVIDER OR SUPPLIER   |  |         | ST                                     | TREET ADDRESS, CITY, STATE, ZIP CODE   | •   |                                     |
| WOODB                    | WOODBURY HEALTH CARE CENTER  |  |         |  | 012 LAKE ROAD<br>OODBURY, MN 55125   |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |         |  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE          |
| F 441                    | transport linens so<br>infection.<br>This REQUIREMEI<br>by:<br>Based on observat<br>review, the facility f<br>was provided for 2<br>observed during ca<br>mechanical stand li<br>Findings include:<br>On 2/3/16, at 10:21<br>(NA)-E, was observ<br>R161 with standing<br>lift. R161 grabbed t<br>NA-E assisted R16<br>removing the dispo | nge 17<br>ndle, store, process and<br>as to prevent the spread of<br>NT is not met as evidenced<br>tion, interview and document<br>ailed to ensure hand hygiene<br>of 4 residents (R161, R96)<br>res and failed to ensure the<br>ft was sanitized between uses.<br>a.m., nursing assistant,<br>ved to don gloves and assist<br>using the mechanical stand<br>he handles as she stood.<br>1 to sit on the toilet after<br>sable brief. R161 urinated in<br>ed disposable wipes to clean | F 441   |  | The preparation of the following pl<br>correction of this<br>deficiency does not constitute and<br>not be interpreted as an admission<br>agreement by the facility of the trut<br>facts alleged on conclusions set for<br>the statement of deficiencies. The<br>correction prepared for this deficier<br>executed solely because it is requir<br>provisions of State of Law. Without<br>waiving the forgoing statement, the<br>states that:<br>1. Staff immediately sanitized the<br>mechanical standing device and re<br>hands.   | should<br>nor an<br>h of the<br>rth in<br>plan of<br>ncy was<br>red by<br>c<br>facility |                                     |
|                          | R161, assisted R16<br>stand by holding the<br>stand lift. NA-E the<br>her wheelchair. NA<br>without washing or<br>door to R161's roor<br>lift to the storage ro<br>unwashed hands, a<br>stand lift into the sto<br>proceeded to open<br>unwashed hands, a<br>by straightening ou<br>NA-E did not sanitiz<br>after assisting R16          | 51 with applying a brief and to<br>e handles of the mechanical<br>n assisted R161 to sit down in<br>-E removed gloves, and<br>sanitizing hands, opened the<br>m, took the mechanical stand<br>oom and opened the door with<br>and pushed the mechanical<br>orage room. NA-E then<br>the door to R96's room, using<br>and began to make R96's bed<br>t the linens and blankets.<br>ze the mechanical stand lift<br>1 with using the toilet.   |         |  | <ol> <li>With respect to identified employ<br/>education was provided to ensure p<br/>hand washing and cleaning of equi<br/>was provided between resident car<br/>February 3, 2016.</li> <li>All nursing staff will be re educat<br/>regarding hand washing and disinfer<br/>resident equipment between resident<br/>by March 15, 2016</li> <li>The Director of Nursing and/or<br/>designee will audit 5 resident cares<br/>week for one month and 3 resident<br/>each week for 2 months to assure<br/>hand washing and disinfection of<br/>equipment is occurring.</li> </ol> | eroper<br>pment<br>res on<br>red<br>ecting<br>ent use<br>s each<br>c cares              |                                     |

Facility ID: 00803

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| TATEMENT                 |   | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · ,                                  | PLE CONSTRUCTION   | (X3) DAT | . 0938-039<br>E SURVEY<br>IPLETED |  |
|--------------------------|---|---|--------------------------------------|--|----------|-----------------------------------|--|
|                          |   |   | A. BUILDIN                           | G  |          |                                   |  |
|                          |   | 245235  | B. WING                              |  | 02/      | 04/2016                           |  |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                                      | STREET ADDRESS, CITY, STATE, ZIP CODE  |          |                                   |  |
| WOODB                    | URY HEALTH CARE (   | CENTER  | 7012 LAKE ROAD<br>WOODBURY, MN 55125 |  |          |                                   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                  | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | LD BE    | (X5)<br>COMPLETIC<br>DATE         |  |
| F 441                    | had last washed or<br>reported he perform<br>assisting R161 with<br>continued to straigh<br>unwashed hands. It<br>sanitize the mecha<br>prior to putting in st<br>On 2/3/16, at 10:36<br>floor manager, (RN<br>perform hand hygic<br>with using the toilet<br>the mechanical sta<br>storage as someon<br>away.<br>The Hand Washing<br>directed staff "Hand<br>and effective steps<br>Dry) to reduce the st<br>respiratory illness.<br>particularly before a<br>one of the best way<br>getting sick, and pr<br>others." The policy | ked at this time when NA-E<br>sanitized his hands, NA-E<br>ned hand hygiene prior to<br>using the toilet. NA-E then<br>hten out R96's bed linens with<br>NA-E reported he did not<br>nical stand lift after use and | F 44                                 | 1<br>5. The data collected will be pres<br>QAPI by the Director of Nursing.<br>will be reviewed/discussed and<br>decision/recommendations made<br>regarding any necessary follow u<br>studies. | The data |                                   |  |
|                          | directed staff "21. W<br>mechanical lift with<br>483.70(h)  | t Policy, last revised 12/2013,<br>Wipe handles of the<br>a germicidal cloth." after use.<br>AL/SANITARY/COMFORTABL   | F 46                                 | 5  |          | 3/15/16                           |  |
|                          |   | ovide a safe, functional,<br>ortable environment for  |                                      |  |          |                                   |  |

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If continuation sheet Page 19 of 21

|                             |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |  |   | FORM   | 03/02/2016<br>APPROVED<br>0938-0391 |
|-----------------------------|---|---|---------------------|--|---|--|-------------------------------------|
| STATEMENT                   | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED  |                                     |
|                             |   | 245235  | B. WING             |  |   | 02/0   | 04/2016                             |
| NAME OF                     | NAME OF PROVIDER OR SUPPLIER  |   |                     | ST                                     | TREET ADDRESS, CITY, STATE, ZIP CODE  |  |                                     |
| WOODBURY HEALTH CARE CENTER |   |   |                     |  | 012 LAKE ROAD<br>OODBURY, MN 55125  |  |                                     |
| (X4) ID<br>PREFIX<br>TAG    | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG | ×                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)   | BE   | (X5)<br>COMPLETION<br>DATE          |
| F 465                       | residents, staff and  | the public.   | F 4                 | 65                                     |   |  |                                     |
|                             | by:<br>Based on observat<br>failed to ensure cup<br>6 kitchenettes were<br>good repair. This ha<br>165 residents resid<br>Findings include:<br>During the final kitc<br>a.m. to 10:25 a.m. t<br>kitchenette cabinets<br>2 West units were r<br>raw wood in some p<br>doors of the 3 North<br>spots/spills down th<br>In the 3 North dining<br>of 5 drawers were v<br>making the surface<br>In the 1 West dining<br>of 6 upper kitchene<br>touch and debris wa<br>touching the cabine<br>nutritional services<br>cabinets, stated the<br>housekeeper in the<br>The director of nutri<br>a.m. that maintenar<br>cupboards and see<br>and refinished. The<br>stated it was house | hen tour on 2/4/16, from 9:35<br>he wood finishes of lower<br>is in the 3 North, 3 South, and<br>noted to be worn down to the<br>places. The lower cabinet<br>in and 2 West units had white<br>e front of the doors.<br>g room the inside bottom of 3<br>worn down to the raw wood, |                     |  | The preparation of the following pla<br>correction of this<br>deficiency does not constitute and s<br>not be interpreted as an admission<br>agreement by the facility of the truth<br>facts alleged on conclusions set for<br>the statement of deficiencies. The p<br>correction prepared for this deficient<br>executed solely because it is require<br>provisions of State of Law. Without<br>waiving the forgoing statement, the<br>states that:<br>1. With respect to the identified kito<br>cabinets, all identified cabinets have<br>cleaned and repaired.<br>2. Environmental Rounds have bee<br>conducted to identify any items in n<br>repair.<br>3. All staff will be re educated regar<br>reporting items in need of repair by<br>15, 2016<br>4. The Director of Maintenance and<br>designee will complete audits week<br>months and then on a monthly basi<br>make needed repairs or schedule la<br>projects.<br>5. The data collected will be present<br>QAPI by the Director of Maintenance<br>data will be reviewed/discussed and<br>decision/recommendations will be r<br>regarding any necessary follow up<br>studies. | should<br>nor an<br>of the<br>th in<br>blan of<br>ncy was<br>ed by<br>facility<br>hen<br>e been<br>en<br>eed of<br>ding<br>March<br>l/or<br>ly for 3<br>s to<br>arger<br>eted at<br>ce. The<br>d |                                     |

|                          |                                  | AND HUMAN SERVICES  |  |                                      |   | FORM                          | 03/02/2016<br>APPROVED<br>0938-0391 |  |  |
|--------------------------|----------------------------------|---|--|--------------------------------------|---|-------------------------------|-------------------------------------|--|--|
|                          | OF DEFICIENCIES<br>OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                               | (X2) MULTIPLE CONSTRUCTION A. BUILDING |                                      |   | (X3) DATE SURVEY<br>COMPLETED |                                     |  |  |
|                          |                                  | 245235  | B. WING                                | i                                    |   | 02/                           | 04/2016                             |  |  |
| NAME OF I                | PROVIDER OR SUPPLIER             |   | -                                      |                                      | STREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |  |  |
| WOODB                    | WOODBURY HEALTH CARE CENTER      |   |  | 7012 LAKE ROAD<br>WOODBURY, MN 55125 |   |                               |                                     |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                 | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG                      |                                      | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |  |  |
| F 465                    |                                  | able to provide a preventative aning schedule for the                               | F                                      | 465                                  |   |                               |                                     |  |  |
|                          |                                  |   |  |                                      |   |                               |                                     |  |  |
|                          |                                  |   |  |                                      |   |                               |                                     |  |  |

Facility ID: 00803

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

| FS | 23 | 50 | 26 |
|----|----|----|----|
|    |    |    |    |

PRINTED: 03/02/2016 FORM APPROVED OMB NO. 0938-0391

|                          | TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA<br>DPLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | 1`´´               |     | CONSTRUCTION<br>- MAIN BUILDING 01   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|--------------------|-----|--|-------------------------------|----------------------------|
|                          |   | 245235  | B: WING            |     |  | 02/04/2016                    |                            |
|                          | PROVIDER OR SUPPLIER  | CENTER  |                    | 701 | EET ADDRESS, CITY, STATE, ZIP COD<br>2 LAKE ROAD<br>ODBURY, MN 55125                                 | E                             |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | IOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| K 000                    | INITIAL COMMEN  | rs  | ĸ                  | 000 |  |                               |                            |
|                          | ALLEGATION OF O<br>DEPARTMENT'S A<br>SIGNATURE AT TH<br>PAGE OF THE CM  | OC WILL SERVE AS YOUR<br>COMPLIANCE UPON THE<br>CCEPTANCE. YOUR<br>HE BOTTOM OF THE FIRST<br>S-2567 FORM WILL BE  |                    |     |  |                               |                            |
| ÷                        | UPON RECEIPT O<br>ONSITE REVISIT<br>CONDUCTED TO<br>SUBSTANTIAL CO<br>REGULATIONS HA  | ATION OF COMPLIANCE.<br>F AN ACCEPTABLE POC, AN<br>DF YOUR FACILITY MAY BE<br>VALIDATE THAT<br>MPLIANCE WITH THE<br>AS BEEN ATTAINED IN<br>ITH YOUR VERIFICATION. |                    |     |  |                               |                            |
|                          | Minnesota Departm<br>time of this survey,<br>was found not in su<br>requirements for pa<br>Medicare/Medicaid<br>483.70(a), Life Safe<br>edition of National I | at 42 CFR, Subpart<br>ety from Fire, and the 2000<br>Fire Protection Association<br>01, Life Safety Code (LSC),   | 13                 |     |  | 5                             |                            |
| ,                        | DEFICIENCIES (K-<br>HEALTHCARE FIR<br>STATE FIRE MARS<br>445 MINNESOTA S<br>ST. PAUL, MN 551  | R THE FIRE SAFETY<br>TAGS) TO:<br>E INSPECTIONS<br>SHAL DIVISION<br>STREET, SUITE 145   |                    |     | EPO  | C                             |                            |
|                          | Or by email to:<br>Marian.Whitney@s   | tate.mn.us and  |                    |     |  |                               |                            |
|                          | DIRECTOR'S OR PROVID  | ER/SUPPLIER REPRESENTATIVE'S SIG  | NATURE             |     | TITLE  |                               | (X6) DATE<br>02/25/2016    |

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

|                          |   | AND HUMAN SERVICES   |                    |     |   | FORM | 03/02/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|-----|---|------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | PLE CONSTRUCTION<br>6 01 - MAIN BUILDING 01   |      | E SURVEY<br>PLETED                  |
|                          |   | 245235   | B. WING            | ;   |   | 02/  | 04/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                    | [   | STREET ADDRESS, CITY, STATE, ZIP CODE   |      |                                     |
| WOODB                    | URY HEALTH CARE (   | ENTER  |                    |     | 7012 LAKE ROAD  |      |                                     |
|                          |   |  |                    |     | WOODBURY, MN 55125  |      |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE          |
| K 000                    | Continued From pa<br>Angela.Kappenmar   |  | ĸ                  | 000 | )   |      |                                     |
|                          |   | RRECTION FOR EACH<br>T INCLUDE ALL OF THE<br>DRMATION:   |                    |     |   |      |                                     |
|                          | 1. A description of v<br>to correct the defici  | what has been, or will be, done<br>ency.   |                    |     |   |      |                                     |
|                          | 2. The actual, or pr  | oposed, completion date.   |                    |     |   |      |                                     |
|                          |   | r title of the person<br>rection and monitoring to<br>ence of the deficiency.  |                    |     |   |      | 4                                   |
|                          | with no basement.<br>at 2 different times.<br>was constructed in<br>be of Type II(222) of<br>floor addition was of<br>determined to be of<br>Because the original | are Center is a 4-story building<br>The building was constructed<br>The original 3 story building<br>1979 and was determined to<br>construction. In 1986, a fourth<br>constructed that was<br>f Type II(222) construction.<br>al building and the 1 addition<br>the of construction, the facility<br>the building. |                    |     |   |      |                                     |
|                          | has a fire alarm sys<br>the corridors and sy<br>that is monitored fo<br>notification. The fac   | fire sprinklered. The facility<br>stem with smoke detection in<br>paces open to the corridors<br>r automatic fire department<br>cility has a capacity of 175<br>hsus of 158 at the time of the   |                    |     |   |      |                                     |
|                          | Surveyor that the fir<br>resident rooms is w<br>provide complete u  | on of this Life Safety Code<br>re sprinkler coverage in the<br>rithin 3 feet and adequate to<br>nobstructed coverage to the<br>robe closets in accordance  |                    |     |   |      |                                     |

Facility ID: 00803

If continuation sheet Page 2 of 9

| A BULLING UT - MAR BULLING UT - MAR BULLING UT       245235       E WING       02/04/2016         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE<br>TO12 LAKE ROAD<br>WOODBURY HEALTH CARE CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE<br>TO12 LAKE ROAD<br>WOODBURY, NN 55125         WOUT TAG       SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY UNST BE PREAEDED BY FILL<br>REGULATORY OR LSC DEATIFYING INFORMATION)       ID<br>PREAK<br>REGULATORY OR LSC DEATIFYING INFORMATION)       PREAK<br>PREAK<br>REGULATORY OR LSC DEATIFYING INFORMATION)       PREAK<br>PREAK<br>REGULATORY OR LSC DEATIFYING INFORMATION)       PREAK<br>REGULATORY OR LSC DEATIFYING INFORMATION)       <  |           | OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIF | PLE CONSTRUCTION  |  | E SURVEY                  |
|--|-----------|--|---|-------------|---|--|---------------------------|
| AMA E OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         YOODBURY HEALTH CARE CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         YOUDBURY HEALTH CARE CENTER       TO CONTRECTION         (X4) ID<br>PREFIX<br>TAG       SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDER'S FLAN OF CORRECTION<br>(EACH ORRECTIVE ACTION SHOULD BE<br>CROSSREFERENCED TO THE APPROPRIATE<br>DEFICIENCY)       OVEL<br>(EACH ORRECTIVE ACTION SHOULD BE<br>CROSSREFERENCED TO THE APPROPRIATE<br>DEFICIENCY) <t< th=""><th>ID PLAN O</th><th>FCORRECTION</th><th>IDENTIFICATION NUMBER:</th><th>A, BUILDING</th><th>3 01 - MAIN BUILDING 01</th><th colspan="2">COMPLETED</th></t<> | ID PLAN O | FCORRECTION  | IDENTIFICATION NUMBER:  | A, BUILDING | 3 01 - MAIN BUILDING 01   | COMPLETED  |                           |
| WOODBURY HEALTH CARE CENTER     7012 LAKE ROAD<br>WOODBURY, IMI 55125       (X4) ID<br>TAG     SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATIONY OR LSC IDENTFYING INFORMATION)     ID<br>PERV<br>(EACH CORRECTOR A CTION SHOLD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)     ID<br>(EACH CORRECTOR A CTION SHOLD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)     IO<br>(M)<br>(EACH CORRECTOR A CTION SHOLD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)     IO<br>(M)<br>(EACH CORRECTOR A CTION SHOLD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)     IO<br>(M)<br>(M)<br>(M)<br>(M)<br>(M)<br>(M)<br>(M)<br>(M)<br>(M)<br>(M)   |           | - 245235   |   | B. WING     |   | 02/04/2016   |                           |
| WOODBURY HEALTH CARE CENTER         WOODBURY, MN 55125           (X4) ID<br>SURMARY STATEMENT OF DEFICIENCIES<br>TAG         SURMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST EE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         ID<br>PROVIDENT ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)         (M0)<br>COMPLET<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY         (M0)<br>COMPLET<br>SURFACE           K 000         Continued From page 2<br>with NFPA 13 (99) and CMS S&C-05-38, A1.         K 000         K 018         4/15/16           SS=F         Doors protecting corridor openings in other than<br>required enclosures of vertical openings, exits, or<br>hazardous areas shall be subbantial doors, such<br>as those constructed of 13/4 inch solid-bonded<br>core wood, or capable of resisting fire for at least<br>20 minutes. Clearance between bottom of door<br>and floor covering is not exceeding 1 inch. Doors<br>in fully sprinklered smoke compartments are only<br>required to resist the passage of smoke. There is<br>no impediment to the closing of the doors. Hold<br>open devices that release when the door is<br>pushed or pulled are permitted. Doors shall be<br>provided with a means suitable for keeping the<br>door closed. Dutch doors meeting 19.3.6.3 for<br>permitted. Door shall be labeled and<br>made of steel or other materials in compliance<br>with 8.2.3.2.1. Roller latches are prohibited by<br>CMS regulations in all health care facilities.<br>19.3.6.3         The preparation of the following plan of<br>correction of this deficiency does not<br>constitute and should not be interpreted<br>as an admission nor an agreement by the<br>facility of the truth of this deficient practice could affect the<br>or latch This deficient practice could affect the<br>safety of approximately 113 of 175 residents and   | AME OF F  | PROVIDER OR SUPPLIER   |   |             | STREET ADDRESS, CITY, STATE, ZIP CODE   |  |                           |
| PREFX<br>TAG       (EACH CORRECTIVE ACTION SHOULD BE<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX<br>TAG       (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REPERENCED TO THE APPROPRIATE<br>DEFICIENCY)       COMILT<br>DEFICIENCY         K 000       Continued From page 2<br>with NFPA 13 (99) and CMS S&C-05-38, A1.       K 000       K 000         NOT MET as evidenced by:       K 018       K 018         SS=F       Doors protecting corridor openings in other than<br>required enclosures of vertical openings, exits, or<br>hazardous areas shall be substantial doors, such<br>as those constructed of 13/4 inch solid-bonded<br>core wood, or capable of resisting fire for at least<br>20 minutes. Clearance between bottom of door<br>and floor covering is not exceeding 1 inch. Doors<br>in fully sprinklered smoke compartments are only<br>required to resist the passage of smoke. There is<br>no impediment to the closing of the doors. Hold<br>open devices that release when the door is<br>pushed or pulled rap emritted. Doors shall be<br>provided with a means suitable for keeping the<br>door closed. Duch doors meeting 19.3.6.3 dare<br>permitted. Door frames shall be labeled and<br>made of steel or other materials in compliance<br>with 8.2.3.2.1. Roller latches are prohibited by<br>CMS regulations in all health care facilities.<br>19.3.6.3<br>This STANDARD is not met as evidenced by:<br>Based on the observation and staff interview, the<br>facility had several corridor doors that did not<br>meet the requirements of NFPA 101 LSC (00)<br>Section 19.3.6.3, they did not fit tight in the frame<br>or latch. This deficient practice could affect the<br>san admission nor an agreement by the<br>facility of the truth of the facts alleged on<br>constitute and should not be interpreted<br>as an admission nor an agreement by the<br>facility of the truth of the facts alleged on<br>constitue and should not be interpreted<br>as an admission nor an agreement   | VOODBI    | JRY HEALTH CARE  | CENTER  |             |   |  |                           |
| <ul> <li>with NFPA 13 (99) and CMS S&amp;C-05-38, A1.</li> <li>The requirement at 42 CFR, Subpart 483.70(a) is<br/>NOT MET as evidenced by:</li> <li>K 018</li> <li>NFPA 101 LIFE SAFETY CODE STANDARD</li> <li>SS=F</li> <li>Doors protecting corridor openings in other than<br/>required enclosures of vertical openings, exits, or<br/>hazardous areas shall be substantial doors, such<br/>as those constructed of 13/4 inch solid-bonded<br/>core wood, or capable of resisting fire for at least<br/>20 minutes. Clearance between bottom of door<br/>and floor covering is not exceeding 1 inch. Doors<br/>in fully sprinklered smoke compartments are only<br/>required to resist the passage of smoke. There is<br/>no impediment to the closing of the doors. Hold<br/>open devices that release when the door is<br/>pushed or pulled are permitted. Doors shall be<br/>provided with a means suitable for keeping the<br/>door closed. Dutch doors meeting 19.3.6.3.6 are<br/>permitted. Door frames shall be labeled and<br/>made of steel or other materials in compliance<br/>with 8.2.3.2.1. Roller latches are prohibited by<br/>CMS regulations in all health care facilities.<br/>19.3.6.3</li> <li>This STANDARD is not met as evidenced by:<br/>Based on the observation and staff interview, the<br/>facility had several corridor doors that did not<br/>meet the requirements of NFPA 101 LSC (00)<br/>Section 19.3.6.3, they did not fit tight in the frame<br/>or latch. This deficient practice could affect the<br/>safety of approximately 113 of 175 residents and</li> </ul>   | PRÉFIX    | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL  | PREFIX      | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE   | BE   | (X5)<br>COMPLETIO<br>DATE |
| <ul> <li>The requirement at 42 CFR, Subpart 483.70(a) is<br/>NOT MET as evidenced by:</li> <li>K 018</li> <li>SS=F</li> <li>Doors protecting corridor openings in other than<br/>required enclosures of vertical openings, exits, or<br/>hazardous areas shall be substantial doors, such<br/>as those constructed of 13/4 inch solid-bonded<br/>core wood, or capable of resisting fire for at least<br/>20 minutes. Clearance between bottom of door<br/>and floor covering is not exceeding 1 inch. Doors<br/>in fully sprinklered smoke compartments are only<br/>required to resist the passage of smoke. There is<br/>no impediment to the closing of the doors. Hold<br/>open devices that release when the door is<br/>pushed or pulled are permitted. Doors shall be<br/>provided with a means suitable for keeping the<br/>door closed. Dutch doors meeting 19.3.6.3 are<br/>permitted. Door frames shall be labeled and<br/>made of steel or other materials in compliance<br/>with 8.2.3.2.1. Roller latches are prohibited by<br/>CMS regulations in all health care facilities.<br/>19.3.6.3<br/>This STANDARD is not met as evidenced by:<br/>Based on the observation and staff interview, the<br/>facility had several corridor doors that did not<br/>meet the requirements of NFPA 101 LSC (00)<br/>Section 19.3.6.3, they did not fit tight in the frame<br/>or latch. This deficient practice could affect the<br/>safety of approximately 113 of 175 residents and</li> </ul>  | K 000     |  | -   | K 00        | )   |  |                           |
| SS=F<br>Doors protecting corridor openings in other than<br>required enclosures of vertical openings, exits, or<br>hazardous areas shall be substantial doors, such<br>as those constructed of 13/4 inch solid-bonded<br>core wood, or capable of resisting fire for at least<br>20 minutes, Clearance between bottom of door<br>and floor covering is not exceeding 1 inch. Doors<br>in fully sprinklered smoke compartments are only<br>required to resist the passage of smoke. There is<br>no impediment to the closing of the doors. Hold<br>open devices that release when the door is<br>pushed or pulled are permitted. Doors shall be<br>provided with a means suitable for keeping the<br>door closed. Dutch doors meeting 19.3.6.3.6 are<br>permitted. Door frames shall be labeled and<br>made of steel or other materials in compliance<br>with 8.2.3.2.1. Roller latches are prohibited by<br>CMS regulations in all health care facilities.<br>19.3.6.3<br>This STANDARD is not met as evidenced by:<br>Based on the observation and staff interview, the<br>facility had several corridor doors that did not<br>meet the requirements of NFPA 101 LSC (00)<br>Section 19.3.6.3, they did not fit tight in the frame<br>or latch. This deficient practice could affect the<br>safety of approximately 113 of 175 residents and  |           | The requirement a  | t 42 CFR, Subpart 483.70(a) is  |             |   |  |                           |
| required enclosures of vertical openings, exits, or<br>hazardous areas shall be substantial doors, such<br>as those constructed of 13/4 inch solid-bonded<br>core wood, or capable of resisting fire for at least<br>20 minutes. Clearance between bottom of door<br>and floor covering is not exceeding 1 inch. Doors<br>in fully sprinklered smoke compartments are only<br>required to resist the passage of smoke. There is<br>no impediment to the closing of the doors. Hold<br>open devices that release when the door is<br>pushed or pulled are permitted. Doors shall be<br>provided with a means suitable for keeping the<br>door closed. Dutch doors meeting 19.3.6.3.6 are<br>permitted. Door frames shall be labeled and<br>made of steel or other materials in compliance<br>with 8.2.3.2.1. Roller latches are prohibited by<br>CMS regulations in all health care facilities.<br>19.3.6.3<br>This STANDARD is not met as evidenced by:<br>Based on the observation and staff interview, the<br>facility had several corridor doors that did not<br>meet the requirements of NFPA 101 LSC (00)<br>Section 19.3.6.3, they did not fit tight in the frame<br>or latch. This deficient practice could affect the<br>safety of approximately 113 of 175 residents and  |           | NFPA 101 LIFE SA   | FETY CODE STANDARD  | K 01        | 3   |  | 4/15/16                   |
| an undetermined number of staff and visitors, if<br>smoke from a fire were allowed to enter the exit<br>access corridors making it untenable.  |           | hazardous areas s<br>as those construct<br>core wood, or capa<br>20 minutes. Cleara<br>and floor covering<br>in fully sprinklered<br>required to resist th<br>no impediment to to<br>open devices that<br>pushed or pulled a<br>provided with a me<br>door closed. Dutch<br>permitted. Door fra<br>made of steel or of<br>with 8.2.3.2.1. Roll<br>CMS regulations in<br>19.3.6.3<br>This STANDARD<br>Based on the obse<br>facility had several<br>meet the requirem<br>Section 19.3.6.3, th<br>or latch. This defice<br>safety of approxim<br>an undetermined results. | hall be substantial doors, such<br>ed of 13/4 inch solid-bonded<br>able of resisting fire for at least<br>ance between bottom of door<br>is not exceeding 1 inch. Doors<br>smoke compartments are only<br>ne passage of smoke. There is<br>the closing of the doors. Hold<br>release when the door is<br>re permitted. Doors shall be<br>eans suitable for keeping the<br>n doors meeting 19.3.6.3.6 are<br>ames shall be labeled and<br>ther materials in compliance<br>er latches are prohibited by<br>n all health care facilities.<br>is not met as evidenced by:<br>ervation and staff interview, the<br>corridor doors that did not<br>ents of NFPA 101 LSC (00)<br>hey did not fit tight in the frame<br>cient practice could affect the<br>ately 113 of 175 residents and<br>number of staff and visitors, if<br>were allowed to enter the exit |             | correction of this deficiency does no<br>constitute and should not be interpu-<br>as an admission nor an agreement<br>facility of the truth of the facts alleg<br>conclusions set forth in the statement<br>deficiencies. The plan of correction<br>prepared for this deficiency was ex-<br>solely because it is required by pro-<br>of State of Law. Without waiving the | ot<br>reted<br>by the<br>ed on<br>ent of<br>ecuted<br>visions<br>e |                           |

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12.

| TATEMENT      | OF DEFICIENCIES                                | X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIF                       | PLE CONSTRUCTION   |                   | . 0938-039<br>E SURVEY |  |
|---------------|--|--|-----------------------------------|--|-------------------|------------------------|--|
| ND PLAN C     | OF CORRECTION                                  | IDENTIFICATION NUMBER:   | A, BUILDING 01 - MAIN BUILDING 01 |  |                   | COMPLETED              |  |
|               |  | 245235   | B. WING                           |  |                   | 04/2016                |  |
| NAME OF I     | PROVIDER OR SUPPLIER                           |  |                                   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                   |                        |  |
| NOODB         | URY HEALTH CARE                                | CENTER   |                                   | 7012 LAKE ROAD<br>WOODBURY, MN 55125   |                   |                        |  |
| (X4) ID       | SUMMARY STA                                    | ATEMENT OF DEFICIENCIES  | ID                                | PROVIDER'S PLAN OF CORRECT   | ION               | (X5)                   |  |
| PREFIX<br>TAG |  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                    | PREFIX<br>TAG                     | (EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)                                |                   | COMPLÉTIO<br>DATE      |  |
| K 018         | Continued From pa                              | age 3  | K 018                             | В  |                   |                        |  |
|               | resident room door                             | s did not latch or did not fit   |                                   | 15, 2016   |                   |                        |  |
|               | tightly in the frame.                          |  |                                   | 3. Tim Kraus, Director of Mainter  |                   |                        |  |
|               | 328, 327, 324, 308                             | , 119, 118, 224, 203, 207, 213,<br>. 322.  |                                   | and/or designee will audit all door<br>closures on a quarterly basis to a                                  |                   | -                      |  |
|               |  |  |                                   | the doors maintain a proper and  |                   |                        |  |
|               |  | ice was observed by the<br>ance and the Facility   |                                   | both the latch and frame.  |                   |                        |  |
|               | Administrator.                                 | ance and the Facility  |                                   |  |                   |                        |  |
| K 025<br>SS=F | NFPA 101 LIFE SA                               | FETY CODE STANDARD   | K 02                              | 5  |                   | 2/22/16                |  |
|               | least a one half hou constructed in acco       | all be constructed to provide at<br>ur fire resistance rating and<br>ordance with 8.3. Smoke |                                   |  |                   |                        |  |
|               | atrium wall. Window<br>fire-rated glazing or   | rmitted to terminate at an<br>ws shall be protected by<br>r by wired glass panels and        |                                   |  |                   |                        |  |
|               | steel frames.<br>8.3, 19.3.7.3, 19.3.          |  |                                   |  |                   |                        |  |
|               |  | s not met as evidenced by:<br>tion and staff interview, the                                  |                                   | The preparation of the following   | nlan of           |                        |  |
|               | facility failed to mai walls in accordance     | ntain 2 of the 8 smoke barrier<br>with the following   |                                   | correction of this deficiency does constitute and should not be inte                                       | not<br>preted     |                        |  |
|               |  | 00 NFPA 101, Section<br>1. The deficient practice could                                      |                                   | as an admission nor an agreeme<br>facility of the truth of the facts all                                   |                   |                        |  |
|               | affect 26 of the 175                           |  |                                   | conclusions set forth in the state   | •                 |                        |  |
|               | undetermined amo                               | unt of staff and visitors.   |                                   | deficiencies. The plan of correcti   |                   |                        |  |
|               | Findings include:                              |  |                                   | prepared for this deficiency was<br>solely because it is required by p<br>of State of Law. Without waiving | rovisions         |                        |  |
|               | 2/4/2016 observation                           | between 0830 and 1430 on<br>ons revealed that out of the 8                                   |                                   | forgoing statement, the facility sta<br>1. Dry wall installation and fire wa                               | ates that:<br>III |                        |  |
|               | smoke barriers 2 sr                            |  |                                   | caulking has been completed in t   |                   |                        |  |
|               | penetrations in the<br>a. Second floor in t    | tollowing locations:<br>the storage room between   |                                   | second floor storage room and so of the skyway.  | ourn wing         |                        |  |
|               | rooms 201 and 203                              | i.   |                                   | 2. Date of completion: February 2  |                   |                        |  |
|               | b. Second floor sout to the villas.            | uth wing of the skyway leading   |                                   | 3. Tim Kraus, Director of Mainter<br>and/or designee will complete   | ance              |                        |  |
|               |  |  |                                   | environmental audits weekly for o  |                   |                        |  |
|               | The deficient praction<br>Director of Maintena | ce was observed by the   |                                   | month and then monthly to identi<br>repair any smoke barriers with   | ry and            |                        |  |

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|                          |                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                   |                     |  | (3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--------------------------------------|---|---------------------|--|------------------------------|--|
| ND PLAN U                | CORRECTION                           | IDENTIFICATION NOWBER.  | A. BUILDING         | 01 - MAIN BUILDING 01  | CONFLETED                    |  |
|                          |                                      | 245235  | B. WING             |  | 02/04/2016                   |  |
| NAME OF F                | PROVIDER OR SUPPLIEF                 | 3   |                     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                              |  |
| WOODBI                   | JRY HEALTH CARE                      | CENTER  |                     | 012 LAKE ROAD<br>VOODBURY, MN 55125  |                              |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                      | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                              |  |
| K 025                    | Continued From p                     | age 4   | K 025               |  |                              |  |
|                          | Administrator.                       |   |                     | penetrations.  |                              |  |
|                          |                                      | AFETY CODE STANDARD   | K 029               |  | 2/19/16                      |  |
| SS=E                     | One hour fire rate                   | d construction (with o hour   |                     |  |                              |  |
|                          | fire-rated doors) o                  | r an approved automatic fire  |                     |  |                              |  |
|                          |                                      | em in accordance with 8.4.1   |                     |  |                              |  |
|                          |                                      | otects hazardous areas. When matic fire extinguishing system                            |                     |  |                              |  |
|                          |                                      | areas are separated from  |                     |  |                              |  |
|                          |                                      | moke resisting partitions and   |                     |  |                              |  |
|                          |                                      | self-closing and non-rated or<br>ctive plates that do not exceed                        |                     |  |                              |  |
|                          |                                      | e bottom of the door are  |                     |  |                              |  |
|                          | permitted. 19.3.                     | 2.1   |                     |  |                              |  |
|                          |                                      | is not met as evidenced by:   |                     | The properties of the following plan   |                              |  |
|                          |                                      | ation and staff interview, the<br>aintain smoke-resisting                               |                     | The preparation of the following plan<br>correction of this deficiency does not  |                              |  |
|                          |                                      | rs in 2 of the hazardous rooms  |                     | constitute and should not be interpret   |                              |  |
|                          | in accordance with                   | n the following requirements of   |                     | as an admission nor an agreement b   |                              |  |
|                          |                                      | Section 19.3.2.1. The deficient   |                     | facility of the truth of the facts alleged   |                              |  |
|                          |                                      | ect 70 out of 175 residents and amount of staff and visitors.                           |                     | conclusions set forth in the statemen deficiencies. The plan of correction   |                              |  |
|                          | an undetermined                      |   |                     | prepared for this deficiency was exec  | uted                         |  |
|                          |                                      |   |                     | solely because it is required by provis  | sions                        |  |
|                          | Findings include:                    |   |                     | of State of Law. Without waiving the<br>forgoing statement, the facility states  | that <sup>.</sup>            |  |
|                          | On the facility tour                 | between 0830 and 1430 on  |                     | 1. Dry wall installation and fire wall   | that.                        |  |
|                          | 2/4/2016 observat                    | ions revealed the following   |                     | caulking has been completed in the   |                              |  |
|                          |                                      | zardous rooms as follows.   |                     | second floor boiler room and baseme  |                              |  |
|                          | 1. Penetrations or<br>a Second floor | boiler room located by the  |                     | lobby storage room. Door closures have been replaced to the second floor bo  |                              |  |
|                          | skyway                               |   |                     | door and maintenance storage room  |                              |  |
|                          | b. Storage roon                      | n in the basement lobby located   |                     | the basement.  | 016                          |  |
|                          | in front of the wes                  | t wing entrance   |                     | <ol> <li>Date of completion: February 19, 2</li> <li>Tim Kraus, Director of Maintenance</li> </ol>                     |                              |  |
|                          | 2. Missing door c                    | losers:   |                     | and/or designee will complete door   | -                            |  |
|                          | a. Second floo                       | r boiler room located by the  |                     | closure audits with routine fire drills a  |                              |  |
|                          | skyway                               | e Storage room in the   |                     | on a monthly basis. Environmental an<br>will be conducted weekly for one mor   |                              |  |
|                          | n iviaintenanc                       |   |                     | - which the contract of the weeking the more   | 1111                         |  |

Event ID: T2F121

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| ENIE                     | RS FOR MEDICARE   | & MEDICAID SERVICES   |                     | OME   | 3 NO. 0938-0                |
|--------------------------|---|---|---------------------|---|-----------------------------|
|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | LE CONSTRUCTION (X<br>01 - MAIN BUILDING 01   | 3) DATE SURVEY<br>COMPLETED |
|                          | 245235  |   | B. WING             |   | 02/04/2016                  |
| AME OF F                 | ROVIDER OR SUPPLIER   |   | s                   | TREET ADDRESS, CITY, STATE, ZIP CODE  |                             |
|                          |   | 25NTED  | 7                   | 012 LAKE ROAD   |                             |
| NOODRI                   | JRY HEALTH CARE   | JENTER  | V                   | VOODBURY, MN 55125  |                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA   |                             |
| IAG                      |   |   |                     | DEFICIENCY)   |                             |
| K 029                    | Continued From pa   | age 5   | K 029               |   |                             |
|                          |   | ce was observed by the ance and the Facility  |                     |   |                             |
| K 054<br>SS=F            | NFPA 101 LIFE SA  | FETY CODE STANDARD  | K 054               |   | 2/24/16                     |
|                          | activating door hold<br>maintained, inspec<br>with the manufactu<br>This STANDARD i                           | detectors, including those<br>d-open devices, are approved,<br>ted and tested in accordance<br>rer's specifications. 9.6.1.3<br>s not met as evidenced by:<br>tion and documentation review |                     | The preparation of the following plan   | of                          |
|                          | it was revealed that<br>documentation for<br>detector in accorda<br>(00) Section 9.6.2.1                      | t the facility failed to provide<br>sensitivity testing of smoke<br>ince with NFPA 72 and LSC   |                     | correction of this deficiency does not<br>constitute and should not be interpret<br>as an admission nor an agreement by<br>facility of the truth of the facts alleged<br>conclusions set forth in the statement                                     | ed<br>y the<br>I on         |
|                          | Findings Include:   | wr botwoon 0820 and 1420 on   |                     | deficiencies. The plan of correction<br>prepared for this deficiency was exect<br>solely because it is required by provis   |                             |
|                          | 2/4/2016 during do  | our between 0830 and 1430 on<br>cumentation review and staff<br>ealed that there was no   |                     | of State of Law. Without waiving the forgoing statement, the facility states  |                             |
|                          | documentation for<br>testing and observa<br>detector was missin<br>speech therapy roo<br>from the boiler room | smoke detector sensitivity<br>ations revealed 1 smoke<br>ng from the occupational and<br>m and a heat detector missing<br>n on the second floor located                                     |                     | <ol> <li>A smoke detector sensitivity testing<br/>being completed on all the smoke<br/>detectors in the building by Nardini Fi<br/>Equipment Co.</li> <li>Heat detectors were installed in the</li> </ol>   | g is<br>re                  |
|                          | near the skyway.  | ce was observed by the  |                     | second floor boiler room and smoke<br>detectors in the Occupational/Physica<br>therapy rooms. 2 smoke detectors we<br>installed in the identified areas to meet   | ere                         |
|                          |   | ance and the Facility   |                     | <ul> <li>a. Date of completion: February 24, 2</li> <li>4. Tim Kraus, Director of Maintenance<br/>and/or designee will assure annual<br/>inspections are completed to test and<br/>inspect the fire alarm systems for pro-<br/>operation</li> </ul> | 016<br>e                    |
| K 067                    | NFPA 101 LIFE SA  |   | K 067               | operation   | 3/4/16                      |

|                       |   | AND HUMAN SERVICES   |   | FOR  | D: 03/02/2016<br>M APPROVED<br>O. 0938-0391 |
|-----------------------|---|--|---|--|---|
| STATEMEN              | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |   | PLE CONSTRUCTION (X3) D  | ATE SURVEY<br>OMPLETED                      |
|                       |   | 245235   | B. WING   | 0  | 2/04/2016                                   |
| NAME OF               | NAME OF PROVIDER OR SUPPLIER  |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |
| WOODB                 | WOODBURY HEALTH CARE CENTER   |  |   | 7012 LAKE ROAD<br>WOODBURY, MN 55125   |   |
|                       | SUMMARY STA   |  |   | PROVIDER'S PLAN OF CORRECTION  | (X5)  |
| PREFIX<br>TAG         | REFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTIV           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE CONSTRUCTION   |  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | COMPLETION<br>DATE   |   |
| K 067<br>SS=D         | Continued From pa   | ge 6   | K 06  | 7  |   |
| SS=D<br>K 071<br>SS=D | <ul> <li>with the provisions in accordance with specifications. 19: 19:5:2:2</li> <li>This STANDARD is Based on document that the facility failed damper testing in a 9:3:1. This deficient to enter into another smoke barrier to be could negatively eff and an underterminity visitors.</li> <li>Findings Include:</li> <li>On the facility tour to 2/4/2016 during documentation for the deficient practice documentation for the deficient practice Director of Maintena Administrator.</li> <li>NFPA 101 LIFE SAU Rubbish Chutes, Inc.</li> <li>(1) Any existing line pneumatic rubbish a directly onto any conconstruction to previous and the previous of the document of the directly onto any conconstruction to previous with a fire door asset</li> </ul> | and air conditioning comply<br>of section 9.2 and are installed<br>the manufacturer's<br>0.5.2.1, 9.2, NFPA 90A,<br>as not met as evidenced by:<br>ntation review it was revealed<br>d to provide proof of the fire<br>ccordance with NFPA 101 (00)<br>it practice could allow smoke<br>r compartment causing the<br>eneffective in a fire event and<br>ect 45 of the 175 residents<br>led amount of staff and<br>between 0830 and 1430 on<br>cumentation review and staff<br>ealed that there was no<br>esting and inspection of fire<br>ce was observed by the<br>ance and the Facility<br>FETY CODE STANDARD<br>cinerators and Laundry<br>n and trash chute, including<br>and linen systems, that opens<br>rridor is sealed by fire resistive<br>ent further use or is provided<br>embly having a fire protection<br>new chutes comply with | К 07  | The preparation of the following plan of<br>correction of this deficiency does not<br>constitute and should not be interpreted<br>as an admission nor an agreement by th<br>facility of the truth of the facts alleged on<br>conclusions set forth in the statement of<br>deficiencies. The plan of correction<br>prepared for this deficiency was execute<br>solely because it is required by provision<br>of State of Law. Without waiving the<br>forgoing statement, the facility states tha<br>1. Low voltage Contractors will complete<br>testing and inspection of all dampers.<br>2. Date of completion: March 4, 2016<br>3. Tim Kraus, Director of Maintenance<br>and/or designee will assure completion of<br>routine testing and inspection every 4<br>years | d<br>s<br>t:                                |

Event ID: T2F121

Facility ID: 00803

|                          |   | AND HUMAN SERVICES  |                     |   |  | FORM   | 03/02/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|---------------------|---|--|--|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION<br>IG 01 - MAIN BUILDING 0'   |  |  | E SURVEY<br>PLETED                  |
|                          |   | 245235  | B. WING             |   |  | 02/0   | )4/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY,   | STATE, ZIP CODE  |  |                                     |
| WOODB                    | URY HEALTH CARE (   | ENTER   |                     | 7012 LAKE ROAD  |  |  |                                     |
| HOODE                    |   |   |                     | WOODBURY, MN 551  | 125  |  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORREC<br>CROSS-REFEREN   | PLAN OF CORRECTION<br>TIVE ACTION SHOULD E<br>CED TO THE APPROPRI<br>EFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE          |
| K 071                    | section 9.5.<br>(2) Any rubbish chu   | ige 7<br>ite or linen chute, including<br>and linen systems, is provided  | КO                  | '1  |  | 2  |                                     |
|                          | with automatic extir<br>accordance with 9.<br>(3) Any trash chute   | nguishing protection in   |                     |   |  |  |                                     |
| K 147                    | <ul> <li>protected in accord</li> <li>(4) Existing flue-fed<br/>resistive construction</li> <li>19.5.4, 9.5, 8.4, NF<br/>This STANDARD is</li> <li>Base on observation</li> <li>revealed that the far<br/>sprinkler protection</li> <li>101 (00) section 19</li> <li>deficient practice condition</li> <li>deficient practice condition</li> <li>deficient practice condition</li> <li>well as all staff and</li> <li>On the facility tour the</li> <li>2/4/2016 observation</li> <li>head had been remined</li> <li>on the third floor.</li> <li>The deficient practice</li> <li>Administrator.</li> </ul> | ance with 8.4.<br>I incinerators are sealed by fire<br>on to prevent further use.<br>PA 82<br>s not met as evidenced by:<br>ons and staff interview it was<br>cility failed to maintain<br>in the laundry chute per NFPA<br>.5.4.2, 9.7 and NFPA 82. This<br>build affect the residents in the<br>s the chute passes through as<br>visitors.<br>Detween 0830 and 1430 on<br>ons revealed that a sprinkle<br>loved from the laundry chute<br>ce was observed by the<br>ance and the Facility | K 1.                | correction of this of<br>constitute and sho<br>as an admission of<br>facility of the truth<br>conclusions set for<br>deficiencies. The<br>prepared for this of<br>solely because it if<br>of State of Law. W<br>forgoing statemen<br>1. The identified la<br>had a sprinkler ins<br>Viking Sprinkler.<br>2. Verification date<br>3. Tim Kraus, Dire<br>and/or designee w<br>annual fire sprinkl<br>records of inspect | deficiency was exe<br>s required by provi<br>vithout waiving the<br>nt, the facility states<br>aundry chute alread<br>stalled as verified b<br>e as in place: 2/6/1<br>ector of Maintenand<br>vill assure completi<br>er inspections and | t<br>eted<br>by the<br>d on<br>nt of<br>cuted<br>isions<br>s that:<br>dy<br>by<br>6.<br>ce<br>ion of<br>retain | 2/22/16                             |
| K 147<br>SS=D            | Electrical wiring and accordance with Na (NFPA 99) 18.9.1, 1  | FETY CODE STANDARD<br>d equipment shall be in<br>ational Electrical Code. 9-1.2<br>9.9.1<br>s not met as evidenced by:  | K 1                 | 7   |  |  | 2/22/16                             |

Facility ID: 00803

If continuation sheet Page 8 of 9

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | LE CONSTRUCTION<br>01 - MAIN BUILDING 01   | (X3) DATE SURVEY<br>COMPLETED<br>02/04/2016   |                            |
|--------------------------|--|---|---------------------|--|---|----------------------------|
|                          |  | 245235  | B. WING             |  |   |                            |
| AME OF                   | PROVIDER OR SUPPLIER   |   | 5                   | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |                            |
| VOODB                    | URY HEALTH CARE  | CENTER  |                     | 012 LAKE ROAD<br>WOODBURY, MN 55125  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)  | JLD BE  | (X5)<br>COMPLETION<br>DATE |
| К 147                    | facility failed to ma<br>accordance with N<br>Code this deficient<br>affect the safety of<br>Findings include:<br>On the facility tour<br>2/4/2016 observati<br>2 resident rooms u<br>devices as well as<br>tap in series. | tion and staff interview the<br>intain electrical devices in<br>FPA 70 (99), National Electrical<br>practice could negatively | К 147               | The preparation of the following<br>correction of this deficiency does<br>constitute and should not be inter<br>as an admission nor an agreeme<br>facility of the truth of the facts all<br>conclusions set forth in the state<br>deficiencies. The plan of correct<br>prepared for this deficiency was<br>solely because it is required by p<br>of State of Law. Without waiving<br>forgoing statement, the facility st<br>1. All unlisted power tap devices<br>been removed. Twin City Electric<br>updated offices that required add<br>power sources.<br>2. Date of completion: February<br>3. Tim Kraus, Director of Mainter<br>and/or designee will complete<br>environmental audits weekly for<br>month and then monthly to ident<br>remove any unlisted power tap devices | s not<br>rpreted<br>eged on<br>ment of<br>ion<br>executed<br>provisions<br>the<br>tates that:<br>have<br>cians has<br>ditional<br>22, 2016<br>nance<br>one<br>ify and |                            |

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# PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted February 16, 2016

Mr. Allan Barr, Administrator Woodbury Health Care Center 7012 Lake Road Woodbury, Minnesota 55125

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5235027

Dear Mr. Barr:

The above facility was surveyed on February 1, 2016 through February 4, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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,

Woodbury Health Care Center February 16, 2016 Page 2

"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 Susanne Reuss, Unit Supervisor at (651) 201-3793.

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,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility Licensing and Certification File

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CC<br>A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED      |                        |
|--------------------------|---|---|----------------------------------|---|------------------------------------|------------------------|
|                          |   |   |                                  |   |                                    |                        |
|                          |   | 00803   | B. WING                          |   | 02                                 | /04/2016               |
| AME OF PF                | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STATE,             | ZIP CODE  |                                    |                        |
| VOODBU                   | RY HEALTH CARE CEN  | rer 🛛   | KE ROAD<br>SURY, MN 55125        |   |                                    |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | CTION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |
| 2 000                    | Initial Comments  |   | 2 000                            |   |                                    |                        |
|                          | ****ATTEN   | TION*****   |                                  |   |                                    |                        |
|                          | NH LICENSING CORRECTION ORDER   |   |                                  |   |                                    |                        |
|                          | 144A.10, this correcting<br>pursuant to a survey.<br>found that the deficience<br>herein are not correction<br>not corrected shall be<br>with a schedule of finithe Minnesota Depart<br>Determination of whe<br>corrected requires correquirements of the minnes<br>requirements of the minnes of the minnes of the minnes<br>When a rule contains<br>comply with any of the<br>lack of compliance. If<br>re-inspection with any<br>result in the assessmit | ther a violation has been   |                                  |   |                                    |                        |
|                          | that may result from r<br>orders provided that a  | earing on any assessments<br>non-compliance with these<br>a written request is made to<br>n 15 days of receipt of a<br>for non-compliance.                      |                                  |   |                                    |                        |
|                          | receipt of State licens<br>the Minnesota Depar<br>Informational Bulletin  | articipate in the electronic<br>sure orders consistent with<br>tment of Health<br>14-01, available at<br>te.mn.us/divs/fpc/profinfo/inf<br>licensing orders are |                                  |   |                                    |                        |

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

(X6) DATE

|                          | F OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING:                                       |   |                                   | E SURVEY<br>PLETED      |  |
|--------------------------|---|---|--|---|-----------------------------------|-------------------------|--|
|                          |   | 00000   | B. WING  |   |                                   |                         |  |
|                          | ROVIDER OR SUPPLIER   | 00803   | B. WING         02/04/2016           ET ADDRESS, CITY, STATE, ZIP CODE |   |                                   |                         |  |
|                          | RY HEALTH CARE CEN  | 7012 LA   | KE ROAD  | ,   |                                   |                         |  |
|                          |   | WOODB   | URY, MN 55125  |   |                                   |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 000                    | Continued From page   | e 1   | 2 000  |   |                                   |                         |  |
|                          | you electronically. All<br>is necessary for State<br>enter the word "corre<br>text. You must then in<br>State licensure proce<br>completion date, the<br>corrected prior to elec<br>Minnesota Departme<br>On February 1, 2, 3, 4<br>Department's staff, vit<br>the following correction<br>Please indicate in you<br>correction that you has<br>and identify the date<br>Minnesota Departme<br>the State Licensing C<br>federal software. Tag | 4, 2016, surveyors of this<br>isited the above provider and<br>on orders are issued.<br>ur electronic plan of<br>ave reviewed these orders,<br>when they will be completed.<br>nt of Health is documenting<br>Correction Orders using |  |   |                                   |                         |  |
|                          | column entitled "ID F<br>statute/rule out of cor<br>"Summary Statement<br>and replaces the "To<br>correction order. This<br>findings which are in<br>after the statement, "<br>evidence by." Followi<br>are the Suggested M<br>Time period for Correct<br>PLEASE DISREGAR<br>FOURTH COLUMN V<br>"PROVIDER'S PLAN  | D THE HEADING OF THE<br>WHICH STATES,<br>OF CORRECTION." THIS<br>RAL DEFICIENCIES ONLY.   |  |   |                                   |                         |  |

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO<br>A. BUILDING: |  |                                   | E SURVEY<br>PLETED      |  |
|--------------------------|---|--|----------------------------------|--|-----------------------------------|-------------------------|--|
|                          |   | 00803  | B. WING                          |  | 02                                | 02/04/2016              |  |
| NAME OF PI               | ROVIDER OR SUPPLIER   | STREET A   | ADDRESS, CITY, STATE             | , ZIP CODE   | 1                                 |                         |  |
| NOODBU                   | RY HEALTH CARE CEN  | TER  | KE ROAD<br>SURY, MN 55125        |  |                                   |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIENT | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 000                    | Continued From page   | e 2  | 2 000                            |  |                                   |                         |  |
|                          |   | JIREMENT TO SUBMIT A<br>TION FOR VIOLATIONS OF<br>STATUTES/RULES.  |                                  |  |                                   |                         |  |
| 2 560                    | MN Rule 4658.0405 Subp. 2 Comprehensive<br>Plan of Care; Contents   |  | 2 560                            |  |                                   |                         |  |
|                          | objectives and timeta<br>long- and short-term<br>and mental and psyc<br>identified in the comp<br>assessment. The co<br>must include the indiv                      | of care must list measurable<br>ables to meet the resident's<br>goals for medical, nursing,<br>hosocial needs that are<br>orehensive resident<br>mprehensive plan of care<br>vidual abuse prevention plan<br>ca Statutes, section 626.557,                                   |                                  |  |                                   |                         |  |
|                          | by:<br>Based on observation<br>review, the facility fai<br>of hand contractures   | nt is not met as evidenced<br>n, interview and document<br>led to identify the presence<br>in the care plan for 1 of 2<br>or range of motion, (R181).  |                                  |  |                                   |                         |  |
|                          | Findings include:   |  |                                  |  |                                   |                         |  |
|                          | data set [MDS], a sig<br>completed on 9/16/19<br>functional impairmen<br>in both upper extremi<br>MDS revealed no fun<br>of motion in the uppe<br>MDS revealed R181 | comprehensive minimum<br>nificant change assessment<br>5, revealed R181 had<br>t in range of motion (ROM)<br>ities. The 12/9/15, quarterly<br>actional impairment in range<br>or extremities. The 12/9/15,<br>had short and long term<br>ad significant impairment in<br>ty. |                                  |  |                                   |                         |  |

|                          | OF DEFICIENCIES<br>OF CORRECTION  | h<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING:       |  |                                   | E SURVEY<br>PLETED      |
|--------------------------|---|--|--|--|-----------------------------------|-------------------------|
|                          |   |  | B. WING                                |  |                                   |                         |
|                          |   | 00803  |  | 02   | 2/04/2016                         |                         |
|                          | ROVIDER OR SUPPLIER   | 7012 LA  | DDRESS, CITY, STATE,<br><b>KE ROAD</b> | , ZIF CODE   |                                   |                         |
| OODBU                    | RY HEALTH CARE CEN  | TER WOODB  | URY, MN 55125                          |  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 560                    | Continued From page   | e 3  | 2 560                                  |  |                                   |                         |
|                          | manager, (RN)-B, rep<br>contracture in her ha<br>range of motion servi<br>device in place.<br>On 2/3/16, at 1:43 p.1<br>observations of R181<br>attempted to uncurl F<br>contracted with finge<br>said "ouch" and RN-F<br>uncurl R181's hand.<br>On 2/3/16, at 1:43 p.1<br>was responsible for c<br>care plan reviewed R<br>R181's contractures<br>reported it was detern<br>benefit from range of<br>device due to it not c<br>her significantly at thi<br>almost all cares for R<br>developed the contra<br>the facility. RN-B and<br>any documentation in<br>to the facility's interdi<br>making process to no<br>splint services for R1<br>appropriate goals and<br>R181's left hand cont | nd and was not receiving<br>ices and did not have a splint<br>m. surveyor made<br>with RN-B. RN-B gently<br>R181's left hand, which was<br>rs in toward the palm. R181<br>B stopped attempting to<br>m. RN-B and RN-C, who<br>completion of the MDS and<br>R181's care plan and reported<br>were not addressed. RN-B<br>mined R181 would not<br>i motion services or a splint<br>ausing her pain or impairing<br>is point since staff provided<br>R181. RN-B reported R181<br>acture in August after a fall at<br>d RN-C were unable to find<br>in the medical record related<br>isciplinary team decision<br>of pursue range of motion or<br>81 and what were<br>d interventions related to<br>tracture. RN-C reported she<br>ist recent quarterly MDS,<br>d have indicated no<br>t in ROM. |  |  |                                   |                         |
|                          | 12/15/15, revealed ne   | o indication R181's left hand<br>ressed in the plan of care  |  |  |                                   |                         |
|                          |   | oletion Policy, last revised<br>to include "Functional   |  |  |                                   |                         |

STATE FORM

|                          | OF DEFICIENCIES<br>OF CORRECTION   | 1<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED     |                          |  |
|--------------------------|--|--|----------------------------------|--|-----------------------------------|--------------------------|--|
|                          |  | 00803  | B. WING                          |  | 02/04/2016                        |                          |  |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREETA  | DDRESS, CITY, STATE,             | ZIP CODE   |                                   |                          |  |
| VOODBU                   | RY HEALTH CARE CENT  | TER  | KE ROAD<br>SURY, MN 55125        |  |                                   |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |
| 2 560                    | Continued From page  | 2 4  | 2 560                            |  |                                   |                          |  |
|                          | Limitations in ROM" in   | n the care plan.   |                                  |  |                                   |                          |  |
|                          | The director of nursin<br>staff to develop a care<br>interventions for all id<br>monitoring program c<br>to assure ongoing and<br>interventions in respo | OD OF CORRECTION:<br>g or designee could direct<br>e plan to include appropriate<br>entified care needs. A<br>ould be established in order<br>d effective care plan<br>nse to resident care needs.<br>CORRECTION: Twenty-one |                                  |  |                                   |                          |  |
| 2 565                    | MN Rule 4658.0405 S<br>Plan of Care; Use   | Subp. 3 Comprehensive  | 2 565                            |  |                                   |                          |  |
|                          |  | prehensive plan of care<br>ersonnel involved in the  |                                  |  |                                   |                          |  |
|                          | by:<br>Based on observatior<br>review, the facility fail   | t is not met as evidenced<br>n, interview and document<br>ed to follow the care plan for<br>ties of daily living for 1 of 3<br>endent on staff for   |                                  |  |                                   |                          |  |
|                          | Findings include:  |  |                                  |  |                                   |                          |  |
|                          | had cognitive loss, wi<br>judgement, decision r<br>processes. The care   |  |                                  |  |                                   |                          |  |

| STATEMENT                | a Department of Healt<br>OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING: |   |                                    | E SURVEY<br>PLETED      |
|--------------------------|---|---|----------------------------------|---|------------------------------------|-------------------------|
|                          |   | 00803   | B. WING                          |   | 02/04/2016                         |                         |
| NAME OF PI               | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STATE              | , ZIP CODE  | 1                                  |                         |
|                          | RY HEALTH CARE CEN  | 7012 LA   | KE ROAD                          |   |                                    |                         |
|                          |   | WOODB   | URY, MN 55125                    |   |                                    |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | CTION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From page   | e 5   | 2 565                            |   |                                    |                         |
|                          |   | mpleting grooming needs.<br>t indicate R125 did not mind  |                                  |   |                                    |                         |
|                          | inch long hairs were and corners of the m   | m. approximately 1/8-1/4th<br>noted on the resident's chin<br>outh. The chin hairs were<br>5, at 8:26 a.m.; on 2/3/16, at<br>I/16, at 8:34 a.m. |                                  |   |                                    |                         |
|                          | stated R125 had a ba<br>but NA-Z had not giv<br>NA-Z state R125 had                               | m. nursing assistant (NA)-Z<br>ath on Saturday evenings,<br>en R125 a bath that evening.<br>I been on NA-Z's<br>3 and 2/4/16, and had not       |                                  |   |                                    |                         |
|                          | attempted to remove<br>dates. NA-Z stated R<br>shaved but would try                               | R125's chin hairs on these<br>125 would "fight" when<br>to remove the chin hairs<br>would allow it. NA-Z verified                               |                                  |   |                                    |                         |
|                          | Program, dated 4/15<br>maintenance program<br>assist to maintain a r<br>level of function and     | ns were to be initiated to<br>esident's highest practicable<br>well-being. The policy   |                                  |   |                                    |                         |
|                          | SUGGESTED METH  | n of grooming for residents.<br>IOD OF CORRECTION: The<br>designee should review  |                                  |   |                                    |                         |
|                          | resident care plans to<br>an accurate reflection<br>the resident. Nursing<br>on ensuring care was | o ensure the care plans were<br>n of the services required by<br>staff could then be educated<br>s provided to residents in                     |                                  |   |                                    |                         |
|                          | of care plans and ob  | h resident's care plan. Audits<br>servation of cares could be<br>care was provided according  |                                  |   |                                    |                         |

| STATEMENT                | a Department of Health<br>OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING: |   | (X3) DATE<br>COMF                 | SURVEY<br>PLETED         |
|--------------------------|---|---|----------------------------------|---|-----------------------------------|--------------------------|
|                          |   | 00803   | B. WING                          |   | 02                                | /04/2016                 |
| NAME OF PI               | ROVIDER OR SUPPLIER   | STREET  | ADDRESS, CITY, STATE             | , ZIP CODE  |                                   |                          |
| NOODBU                   | RY HEALTH CARE CENT   | FR  | KE ROAD<br>SURY, MN 55125        |   |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| 2 565                    | Continued From page   | 96  | 2 565                            |   |                                   |                          |
|                          | to the care plan.   |   |                                  |   |                                   |                          |
|                          | TIME PERIOD FOR (<br>(14) days.   | CORRECTION: Fourteen  |                                  |   |                                   |                          |
| 2 570                    | MN Rule 4658.0405 S<br>Plan of Care; Revisio  | Subp. 4 Comprehensive<br>n  | 2 570                            |   |                                   |                          |
|                          | care must be reviewe<br>interdisciplinary team<br>physician, a registere<br>for the resident, and o<br>disciplines as determi<br>and, to the extent pra<br>participation of the re-<br>guardian or chosen re-<br>quarterly and within s | that includes the attending<br>d nurse with responsibility<br>other appropriate staff in<br>ined by the resident's needs,<br>acticable, with the<br>sident, the resident's legal<br>epresentative at least<br>even days of the revision of<br>esident assessment required |                                  |   |                                   |                          |
|                          | by:<br>Based on observatior<br>review, the facility fail  | t is not met as evidenced<br>n, interview and record<br>ed to ensure the care plan<br>residents (R125) with a<br>n.   |                                  |   |                                   |                          |
|                          | Findings include:   |   |                                  |   |                                   |                          |
|                          | sitting in a Broda chai<br>clenched together in a<br>devices were noted ir<br>nearby. On 2/3/16, at<br>observed holding a gl<br>independently drank f   | n. R125 was observed<br>ir with both hands lightly<br>a fist. No splints or other<br>the resident's hands or<br>8:26 a.m. R125 was<br>ass in the right hand and<br>from the glass. R125 was<br>the left hand, pointer finger  |                                  |   |                                   |                          |

|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING:      |   |                                   | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------------------------|---|-----------------------------------|-------------------------|
|                          |  |   |                                       |   |                                   |                         |
|                          |  | 00803   | B. WING                               |   | 02                                | 2/04/2016               |
| IAME OF PI               | ROVIDER OR SUPPLIER  |   | DDRESS, CITY, STATE<br><b>KE ROAD</b> | , ZIP CODE  |                                   |                         |
| VOODBU                   | RY HEALTH CARE CEN   | TER   | URY, MN 55125                         |   |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 570                    | Continued From page 7<br>to scratch left ear. However, R125 did not entirely<br>open the hand. There was no splint or cloth in<br>R125's left hand.<br>On 2/2/16, at 9:14 a.m. registered nurse (RN)-B<br>stated the facility has tried hand splints for R125<br>in the past and R125 would remove them right<br>away. |   | 2 570                                 |   |                                   |                         |
|                          |  |   |                                       |   |                                   |                         |
|                          |  |   |                                       |   |                                   |                         |
|                          | put cloths in R125's h<br>this time there were r<br>and was asked about<br>R125's left hand. RN<br>hospice at one time a<br>want ROM or anythin  | m. RN-B stated staff would<br>nands. RN-B was informed at<br>no cloths in R125's hands,<br>t range of motion (ROM) to<br>-B stated R125 had been on<br>and the hospice staff did not<br>ng which would cause R125<br>25's had was "very painful." |                                       |   |                                   |                         |
|                          | stated R125 would al<br>hands, and did not co<br>hands were washed.<br>ROM to the left hand<br>allow it. NA-Z stated   | m. nursing assistant (NA)-Z<br>llow staff to wash R125's<br>omplain of pain when the<br>NA-Z stated that gentle<br>during cares if R125 would<br>R125 would not allow a cloth<br>I, as staff had tried that and<br>the cloth.                     |                                       |   |                                   |                         |
|                          | 4/11/14, indicated R1<br>tight, didn't extend all<br>purposefully; had rec<br>(OT) services; refuse<br>caused increased ag<br>were to complete rec   | e plan dated/revised on<br>25 would hold both hands<br>I digits consistently or<br>revived occupational therapy<br>ed to wear splints, as they<br>itation; and nursing staff<br>commendations from OT,<br>he care plan had been                   |                                       |   |                                   |                         |
|                          | 2/3/16, at 3:32 p.m. a   | was reviewed with RN-B on<br>and RN-B was asked why the<br>Iress putting a cloth in   |                                       |   |                                   |                         |

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                  | (X2) MULTIPLE CO<br>A. BUILDING: |  |                                   | E SURVEY<br>PLETED      |
|--------------------------|---|--|----------------------------------|--|-----------------------------------|-------------------------|
|                          |   | 00803  | B. WING                          |  | 02/04/2016                        |                         |
| AME OF PI                | ROVIDER OR SUPPLIER   |  | ADDRESS, CITY, STATE,            | ZIP CODE   | 02                                | /04/2010                |
| OODBU                    | RY HEALTH CARE CEN  | rer 🛛  | KE ROAD                          |  |                                   |                         |
|                          |   |  | SURY, MN 55125                   | PROVIDER'S PLAN O                                      |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                             | ID<br>PREFIX<br>TAG              | (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 570                    | Continued From page   | e 8  | 2 570                            |  |                                   |                         |
|                          | the cloths out. RN-B  | at the resident would take<br>stated the hospice care plan<br>vas not to be completed. |                                  |  |                                   |                         |
|                          |   | ed passive ROM was to be<br>s, except the right arm,                                   |                                  |  |                                   |                         |
|                          | and revised 8/13, ind   | led Care Plan Completion<br>icated a resident's care plan<br>vised as changes occur.   |                                  |  |                                   |                         |
|                          | director of nurse or d  | ed to maintain and/or  |                                  |  |                                   |                         |
|                          | TIME PERIOD FOR (<br>(14) days.   | CORRECTION: Fourteen   |                                  |  |                                   |                         |
| 2 920                    | MN Rule 4658.0525   | Subp. 6 B Rehab - ADLs   | 2 920                            |  |                                   |                         |
|                          | comprehensive resid<br>home must ensure th<br>B. a resident who is<br>activities of daily livin | s unable to carry out<br>g receives the necessary<br>good nutrition, grooming,         |                                  |  |                                   |                         |
|                          | by:<br>Based on observation   | t is not met as evidenced<br>n, interview and document<br>led to provide appropriate   |                                  |  |                                   |                         |

Minnesota Department of STATE FORM

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO<br>A. BUILDING: |   |                                    | E SURVEY<br>PLETED      |
|--------------------------|---|--|----------------------------------|---|------------------------------------|-------------------------|
|                          |   | 00803  | B. WING                          |   | 02/04/2016                         |                         |
| AME OF PI                | ROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STATE,             | , ZIP CODE  |                                    |                         |
| /OODBU                   | RY HEALTH CARE CENT   | rer 🛛  | KE ROAD<br>SURY, MN 55125        |   |                                    |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | CTION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 920                    | Continued From page   | 9  | 2 920                            |   |                                    |                         |
|                          | grooming to 1 of 3 residents (R125) dependent<br>on staff for completion of activities of daily living<br>(ADL.)<br>Findings include:   |  |                                  |   |                                    |                         |
|                          |   |  |                                  |   |                                    |                         |
|                          | inch long hairs were n<br>and corners of the mo<br>still present on 2/2/16<br>8:26 a.m.; and on 2/4<br>On 2/4/16, at 8:59 a.r<br>stated R125 had a ba<br>but NA-Z had not give<br>NA-Z stated R125 ha<br>assignment list for 2/3<br>attempted to remove<br>dates. NA-Z stated R<br>shaved but would try<br>today if the resident w<br>the presence of the c<br>On 2/3/16, at 3:40 p.r | m. nursing assistant (NA)-Z<br>ath on Saturday evenings,<br>en R125 a bath that evening.<br>d been on NA-Z's<br>3 and 2/4/16, and had not<br>R125's chin hairs on these<br>125 would "fight" when<br>to remove the chin hairs<br>vould allow it. NA-Z verified<br>hin hairs at this time.<br>m. a family member stated |                                  |   |                                    |                         |
|                          | On 2/3/16, at 3:47 p.r<br>R125's conservator to   | cial hair would bother R125.<br>m. a message was left for<br>o determine if the facial hair<br>nowever, the conservator  |                                  |   |                                    |                         |
|                          | Program, dated 4/15, maintenance program  | ns were to be initiated to<br>esident's highest practicable  |                                  |   |                                    |                         |
|                          |   | OD OF CORRECTION: The<br>designee should review  |                                  |   |                                    |                         |

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING: |   |                                      | E SURVEY<br>PLETED       |
|--------------------------|---|---|----------------------------------|---|--------------------------------------|--------------------------|
|                          |   | 00803   | B. WING                          |   | 02                                   | 2/04/2016                |
| NAME OF PI               | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STATE,             | ZIP CODE  |                                      |                          |
| NOODBU                   | RY HEALTH CARE CEN  | TER   | KE ROAD<br>URY, MN 55125         |   |                                      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN C<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | CTION SHOULD BE<br>) THE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| 2 920                    | Continued From page   | e 10  | 2 920                            |   |                                      |                          |
|                          | an accurate reflection<br>the resident. Nursing<br>on ensuring care was<br>accordance with each<br>of care plans and obs<br>conducted to ensure<br>to the care plan.                              | o ensure the care plans were<br>n of the services required by<br>staff could then be educated<br>s provided to residents in<br>n resident's care plan. Audits<br>servation of cares could be<br>care was provided according<br>CORRECTION: Fourteen   |                                  |   |                                      |                          |
| 21325                    | MN Rule 4658.0725<br>Emergency Oral Hea   | Subp. 1 Providing Routine & Ith Ser   | 21325                            |   |                                      |                          |
|                          | home must provide,<br>resource, routine der<br>needs of each reside<br>include dental examin<br>fillings and crowns, ro<br>oral surgery, bridges<br>orthodontic procedur<br>that are provided for | dental services. A nursing<br>or obtain from an outside<br>tal services to meet the<br>nt. Routine dental services<br>nations and cleanings,<br>bot canals, periodontal care,<br>and removable dentures,<br>es, and adjunctive services<br>similar dental patients in the<br>as limited by third party<br>es. |                                  |   |                                      |                          |
|                          | by:<br>Based on observation<br>review, the facility fai<br>services were provide  | nt is not met as evidenced<br>n, interview and document<br>led to ensure routine dental<br>ed to 1 of 3 residents (R125)<br>o ensure there were no  |                                  |   |                                      |                          |
|                          | Findings include:   |   |                                  |   |                                      |                          |
|                          |   | m. R125 was observed to<br>ont teeth missing. On 2/3/16,  |                                  |   |                                      |                          |

|               | F OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CC<br>A. BUILDING: |  |                   | E SURVEY<br>PLETED |
|---------------|---|--|----------------------------------|--|-------------------|--------------------|
|               |   | 00803  | B. WING                          |  | 02                | 2/04/2016          |
| AME OF PI     | ROVIDER OR SUPPLIER   |  | DDRESS, CITY, STATE,             | ZIP CODE   | 02                |                    |
| VOODBU        | RY HEALTH CARE CEN  | rer 🛛  |                                  |  |                   |                    |
| (X4) ID       | SUMMARY ST  |  | ID ID                            | PROVIDER'S PLAN (                                    |                   | (X5)               |
| PREFIX<br>TAG |   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG                    | (EACH CORRECTIVE A<br>CROSS-REFERENCED T(<br>DEFICIE | O THE APPROPRIATE | COMPLET            |
| 21325         | Continued From page   | e 11   | 21325                            |  |                   |                    |
|               | size pieces of an ome   | is observed to feed self bite<br>elet and toast. There were<br>ith chewing or swallowing.  |                                  |  |                   |                    |
|               | was to be referred to<br>resident would grind to<br>assess/observe for m<br>Another portion of the<br>9/21/15, noted R125<br>missing, staff perform<br>not participate, but was<br>dentist as needed. How | d on 1/17/14, indicated R125<br>the dentist as needed; the<br>their teeth; and staff were to<br>nouth and tooth issues.<br>e care plan revised on<br>had some natural teeth<br>ned oral care, as R125 did<br>as cooperative; and refer to<br>powever, the care plan did not<br>ot to see the dentist for |                                  |  |                   |                    |
|               | dental service reveale<br>signed the form on 10<br>consulting dental service<br>comprehensive and p<br>There was no indicati  | with the facility's contract<br>ed the conservator had<br>0/11/12, which authorized the<br>vice to provide<br>periodic oral evaluation.<br>ion on the form that the<br>vant the resident to see the  |                                  |  |                   |                    |
|               | record did not indicat  | It section of the medication<br>e R125 had seen a dentist<br>ement had been signed on  |                                  |  |                   |                    |
|               | stated they would che<br>record for any docum<br>visits. By 2/4/16, at 1  | m. registered nurse (RN)-C<br>eck the thinned medical<br>entation regarding dental<br>:00 p.m. RN-C had not been<br>mentation of a dental visit.   |                                  |  |                   |                    |
|               | (HUC)-A stated there<br>screening of R125 at  |  |                                  |  |                   |                    |

|                          | FOF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO<br>A. BUILDING: |   |                                      | E SURVEY<br>PLETED      |
|--------------------------|--|--|----------------------------------|---|--------------------------------------|-------------------------|
|                          |  | 00803  | <br>B. WING                      |   | 0.0                                  | /04/2016                |
| IAME OF PI               | ROVIDER OR SUPPLIER  |  | DDRESS, CITY, STATE,             | ZIP CODE  | 02                                   | /04/2010                |
| VOODBU                   | RY HEALTH CARE CENT  | rer 🛛  | KE ROAD<br>URY, MN 55125         |   |                                      |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN C<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TC<br>DEFICIEI | CTION SHOULD BE<br>D THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21325                    | trying to find the scree<br>contracting dental ser<br>screenings, but provid<br>the facility. HUC-A sta<br>dental issues that the<br>On 2/4/16, at 8:59 a.r<br>stated R125 was resi<br>was not having any p<br>swallowing.<br>The facility's Dental S<br>indicated annual dent | ening. HUC-A stated the<br>rvice did not keep dental<br>ded the documentation to<br>ated R125 had not had any  | 21325                            |   |                                      |                         |
| 21375                    | director of nurses or of<br>resident's legal repres<br>annual dental service<br>dental services were<br>contacting the legal re<br>staff should be made<br>dental needs and how<br>were provided on an<br>TIME PERIOD FOR (<br>(14) days.<br>MN Rule 4658.0800 S<br>Program    | OD OF CORRECTION: The<br>designee could contact the<br>sentative to determine if the<br>swere to be provided or if<br>only to be provided after<br>epresentative. The nursing<br>aware of all resident's<br>v to ensure dental services<br>annual basis.<br>CORRECTION: Fourteen<br>Subp. 1 Infection Control;<br>control program. A nursing | 21375                            |   |                                      |                         |
|                          | home must establish  | and maintain an infection gned to provide a safe and   |                                  |   |                                      |                         |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING:       |  |                                   | SURVEY<br>PLETED       |
|--------------------------|--|---|--|--|-----------------------------------|------------------------|
|                          |  |   | B. WING                                |  |                                   |                        |
|                          |  | 00803   |  |  | 02                                | /04/2016               |
| AIVIE OF Pr              | ROVIDER OR SUPPLIER  |   | ADDRESS, CITY, STATE<br><b>KE ROAD</b> | , ZIP CODE   |                                   |                        |
| OODBU                    | RY HEALTH CARE CEN   | TER   | URY, MN 55125                          |  |                                   |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |
| 21375                    | Continued From pag   | e 13  | 21375                                  |  |                                   |                        |
|                          | by:<br>Based on observatio<br>review, the facility fai<br>was provided for 2 of<br>observed during care<br>mechanical stand lift<br>Findings include:<br>On 2/3/16, at 10:21 at<br>(NA)-E, was observe<br>R161 with standing ut<br>lift. R161 grabbed the<br>NA-E assisted R161<br>removing the dispose<br>the toilet. NA-E used<br>R161, assisted R161<br>stand by holding the<br>stand lift. NA-E then<br>her wheelchair. NA-E<br>without washing or s<br>door to R161's room<br>lift to the storage roo<br>unwashed hands, an<br>stand lift into the stor<br>proceeded to open th<br>unwashed hands, an | n, interview and document<br>iled to ensure hand hygiene<br>f 4 residents (R161, R96)<br>es and failed to ensure the<br>was sanitized between uses. |  |  |                                   |                        |
|                          | after assisting R161   | e the mechanical stand lift<br>with using the toilet.<br>e attached to the mechanical   |  |  |                                   |                        |
|                          | stand lift. When aske<br>had last washed or s<br>reported he performe<br>assisting R161 with u<br>continued to straight  | ed at this time when NA-E<br>anitized his hands, NA-E<br>ed hand hygiene prior to<br>using the toilet. NA-E then<br>en out R96's bed linens with    |  |  |                                   |                        |
|                          |  | A-E reported he did not<br>cal stand lift after use and<br>rage.  |  |  |                                   |                        |

|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO<br>A. BUILDING: |  |                                      | E SURVEY<br>PLETED      |
|--------------------------|--|--|----------------------------------|--|--------------------------------------|-------------------------|
|                          |  | 00803  | B. WING                          |  | 02                                   | /04/2016                |
| NAME OF PI               | ROVIDER OR SUPPLIER  |  | DDRESS, CITY, STATE,             | ZIP CODE   |                                      |                         |
| NOODBU                   | RY HEALTH CARE CEN   | TER  | KE ROAD<br>URY, MN 55125         |  |                                      |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN C<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED TO<br>DEFICIEI | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21375                    | Continued From pag   | e 14   | 21375                            |  |                                      |                         |
|                          | floor manager, (RN)-<br>perform hand hygien<br>with using the toilet a<br>the mechanical stand<br>storage as someone<br>away.  | a.m. the registered nurse<br>B, reported staff should<br>e after assisting a resident<br>and should clean and sanitize<br>d prior to returning it to<br>might need to use it right<br>Policy, last revised 8/2013,   |                                  |  |                                      |                         |
|                          | and effective steps (<br>Dry) to reduce the sp<br>respiratory illness. Re<br>particularly before an<br>one of the best ways<br>getting sick, and prev<br>others." The policy a | vashing involves five simple<br>Wet, Lather, Scrub, Rinse,<br>oread of diarrheal and<br>egular handwashing,<br>id after certain activities, is<br>to remove germs, avoid<br>vent the spread of germs to<br>lso directed staff that hand<br>d if hands were not visibly |                                  |  |                                      |                         |
|                          | directed staff "21. Wi   | Policy, last revised 12/2013,<br>pe handles of the<br>germicidal cloth." after use.  |                                  |  |                                      |                         |
|                          | The director of nursir<br>and revise the policy<br>infection control conc<br>medications, perform<br>cares and provide ed<br>monitoring system co<br>staff are providing ca    | IOD OF CORRECTION:<br>and procedures related to<br>cerns while passing<br>ing wound care, perinal<br>lucation to staff members. A<br>build be developed to ensure<br>res as directed and report<br>lity assurance committee.   |                                  |  |                                      |                         |
|                          | TIME PERIOD FOR<br>(21) days.  | CORRECTION: Twenty-one   |                                  |  |                                      |                         |

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO<br>A. BUILDING:        |   |                                   | E SURVEY<br>PLETED     |
|--------------------------|---|--|---|---|-----------------------------------|------------------------|
|                          |   |  |   |   |                                   |                        |
|                          |   | 00803  |   |   | 02                                | /04/2016               |
| AME OF PF                | ROVIDER OR SUPPLIER   |  | ADDRESS, CITY, STATE,<br><b>KE ROAD</b> | , ZIP CODE  |                                   |                        |
| OODBU                    | RY HEALTH CARE CEI  | NTFR   | BURY, MN 55125                          |   |                                   |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |
| 21426                    | Continued From page   | ge 15  | 21426                                   |   |                                   |                        |
| 21426                    | MN St. Statute 144/<br>Prevention And Cor   | A.04 Subd. 3 Tuberculosis<br>htrol   | 21426                                   |   |                                   |                        |
|                          | maintain a compreh<br>infection control pro<br>current tuberculosis<br>issued by the United<br>Control and Preven<br>Tuberculosis Elimin<br>Morbidity and Morta<br>This program must<br>infection control pla<br>unpaid employees,<br>residents, and volur<br>Health shall provide<br>regarding implement | gram according to the most<br>infection control guidelines<br>d States Centers for Disease<br>tion (CDC), Division of<br>ation, as published in CDC's<br>ality Weekly Report (MMWR).<br>include a tuberculosis<br>n that covers all paid and<br>contractors, students,<br>neteers. The Department of<br>e technical assistance<br>atation of the guidelines. |   |   |                                   |                        |
|                          | by:<br>Based on document<br>facility failed to docu<br>induration results of  | ent is not met as evidenced<br>t review and interview, the<br>ument the interpretation and<br>tuberculin skin test (TST) for<br>5, R87, R148, R249 & R294)   |   |   |                                   |                        |
|                          | Findings include:   |  |   |   |                                   |                        |
|                          | medical record indic<br>dose step of Tubers   | the facility on 5/22/15. R5's<br>cated R5 received the first<br>sol Solution 5 unit/0.1 milliliter<br>on 5/22/15. There were no  |   |   |                                   |                        |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE C      |   |                                    | E SURVEY<br>PLETED     |
|--------------------------|--|--|----------------------|---|------------------------------------|------------------------|
|                          |  |  | B. WING              |   |                                    |                        |
|                          | ROVIDER OR SUPPLIER  | 00803  | ADDRESS, CITY, STATE |   | 02                                 | 2/04/2016              |
|                          |  | 7012 LA  | KE ROAD              | , ZIF CODE  |                                    |                        |
| IOODBU                   | RY HEALTH CARE CEN   | TER WOODB  | SURY, MN 55125       |   |                                    |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | CTION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |
| 21426                    | Continued From pag   | e 16   | 21426                |   |                                    |                        |
|                          | induration of the TST<br>Furthermore, a seco<br>Solution 5 unit/0.1 m<br>given on 6/3/15, and  | e the interpretation or<br>given on 5/22/15.<br>nd dose step of Tubersol<br>illiliter (ML) intradermally was<br>there was no documents to<br>ation or induration of the TST        |                      |   |                                    |                        |
|                          | medical record indica<br>dose step of Tubers<br>(ML) intradermally or<br>documents to indicat<br>induration of the TST<br>Furthermore, a seco<br>Solution 5 unit/0.1 m<br>given on 10/10/15, a | nd dose step of Tubersol<br>illiliter (ML) intradermally was<br>nd there was no documents<br>retation or induration of the   |                      |   |                                    |                        |
|                          | R148's medical reco<br>the first dose step of<br>milliliter (ML) intrade<br>were no documents  | o the facility on 10/18/15.<br>rd indicated R148 received<br>Tubersol Solution 5 unit/0.1<br>rmally on 10/18/15. There<br>to indicate the interpretation<br>ST given on 10/18/15   |                      |   |                                    |                        |
|                          | R249's medical reco<br>the first dose step of<br>milliliter (ML) intrade<br>were no documents  | o the facility on 10/12/15.<br>rd indicated R249 received<br>Tubersol Solution 5 unit/0.1<br>rmally on 10/12/15. There<br>to indicate the interpretation<br>'ST given on 10/12/15. |                      |   |                                    |                        |
|                          | R294's medical reco<br>the first dose step of<br>milliliter (ML) intrade   | o the facility on 11/2/15.<br>rd indicated R294 received<br>Tubersol Solution 5 unit/0.1<br>rmally on 11/2/15. There<br>to indicate the interpretation                             |                      |   |                                    |                        |

| STATEMENT                | a Department of Healt<br>OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO<br>A. BUILDING: |   |                                      | E SURVEY<br>PLETED      |
|--------------------------|---|--|----------------------------------|---|--------------------------------------|-------------------------|
|                          |   | 00803  | B. WING                          |   | 02                                   | 2/04/2016               |
| NAME OF PI               | ROVIDER OR SUPPLIER   | STREET   | ADDRESS, CITY, STATE             | , ZIP CODE  |                                      |                         |
| WOODBU                   | RY HEALTH CARE CEN  | TER  | KE ROAD<br>SURY, MN 55125        |   |                                      |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN C<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEI | CTION SHOULD BE<br>D THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21426                    | Continued From page   | e 17   | 21426                            |   |                                      |                         |
|                          | registered nurse (RN<br>R249 & R294 did not<br>interpretation or induced<br>A review of the facility<br>Screening, read, "TS<br>residents should inclu-<br>day, year). the number<br>(if no induration, docu-<br>interpretation (i.e., por<br>SUGGESTED METH<br>DON or designee cou-<br>screening audits, inter-<br>ensure residents are<br>disease. The DON or<br>staff were educated of | ration of the TST.<br>y policy dated 2013, titled<br>T documentation for<br>ude the date (i.e., month,<br>er of millimeters of induration<br>ument "0" mm), and<br>ositive or negative)."<br>IOD OF CORRECTION: The<br>uld conduct resident<br>erventions and monitoring to<br>free from communicable<br>r designee could ensure the |                                  |   |                                      |                         |
|                          | audit resident's docu<br>documentation for ind  | designee could randomly<br>ments to ensure adequate<br>duration and interpretation.<br>CORRECTION: Fourteen  |                                  |   |                                      |                         |
| 21620                    | MN Rule 4658.1345   |  | 21620                            |   |                                      |                         |
|                          | Drugs used in the nu in accordance with pa  | rsing home must be labeled<br>art 6800.6300.   |                                  |   |                                      |                         |
|                          | by:<br>Based on observation<br>review, the facility fai<br>were stored and labe   | nt is not met as evidenced<br>n, interview and document<br>led to ensure medications<br>led properly for 3 of 45<br>23 and R234) reviewed for  |                                  |   |                                      |                         |

Minnesota Department of Health STATE FORM

6899

If continuation sheet 18 of 29

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO<br>A. BUILDING:       |   |                                      | E SURVEY<br>PLETED      |
|--------------------------|---|--|--|---|--------------------------------------|-------------------------|
|                          |   |  |  |   |                                      |                         |
|                          |   | 00803  | B. WING                                |   | 02                                   | 2/04/2016               |
| NAME OF PI               | ROVIDER OR SUPPLIER   |  | DDRESS, CITY, STATE,<br><b>KE ROAD</b> | , ZIP CODE  |                                      |                         |
| NOODBU                   | RY HEALTH CARE CEN  | TER  | URY, MN 55125                          |   |                                      |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN C<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TC<br>DEFICIEI | CTION SHOULD BE<br>) THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21620                    | Continued From page   | e 18   | 21620                                  |   |                                      |                         |
|                          | medication storage.   |  |  |   |                                      |                         |
|                          | Findings include:   |  |  |   |                                      |                         |
|                          | storage areas through<br>for R332, R123 and F   | of multiple medication<br>hout the facility, medications<br>R234, which included eye<br>nsulins, lacked dates to<br>ere opened.                  |  |   |                                      |                         |
|                          | 9:10 a.m. with register<br>transition care unit ter<br>multiple opened, user<br>bottles were stored in<br>Observations include<br>R332's Azelastine (re<br>bottle was opened, us<br>R332's Ciprodex (for<br>was opened, used an | d the following:<br>edness of eye) eye drop<br>sed and was undated.<br>infection) ear drop bottle<br>ad was undated.<br>abetes) insulin vial was |  |   |                                      |                         |
|                          | properly. RN-A addeo should be dated when   | m. RN-A verified the<br>to be labeled and stored<br>d that opened medications<br>n opened and stated she will<br>ation cart, disposed properly   |  |   |                                      |                         |
|                          | 9:41 a.m., with LPN-A<br>medication storage ca<br>following observation<br>R234's Latanoprost (a<br>bottle was opened, us   | anti-glaucoma) eye drop<br>sed and was undated.  |  |   |                                      |                         |
|                          | On 2/3/16, at 9:41 a.r<br>medications should b<br>properly. LPN-A adde<br>partment of Health  |  |  |   |                                      |                         |

| NUME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       TAG       0(4)10<br>PREFIX<br>TAG     SUMMARY STATEMENT OF DEFICIENCIES<br>((4ACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX<br>TAG     ID<br>PREFIX<br>((4ACH DEFICIENCY MUST BE PRECEDED BY FULL<br>TAG     PROVIDER'S PLAN OF CORRECTION & (000)<br>(CACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX<br>TAG     ID<br>PREFIX<br>((4ACH DEFICIENCY MUST BE PRECEDED BY FULL<br>TAG     PROVIDER'S PLAN OF CORRECTION & (000)<br>(CACH DEFICIENCY<br>MUST BE PRECEDED TO THE PRECEDED BY FULL<br>PREFIX     PROVIDER'S PLAN OF CORRECTION & (000)<br>(CACH DEFICIENCY<br>MUST BE PRECEDED TO THE PRECEDED T | STATEMEN  | a Department of Healt<br>FOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING: |   |                                      | E SURVEY<br>PLETED |
|---|-----------|---|---|----------------------------------|---|--------------------------------------|--------------------|
| ANKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE<br>TAG TOT2 LAKE ROAD<br>WOODBURY, HEALTH CARE CENTER<br>TAG SUMMARY STATEMENT OF DEFICIENCIES<br>TAG CARD BEFICIENCY MUST BE PRECEDED BY FULL<br>TAG CARDETICENCY MUST BE PRECEDED BY FULL<br>TAG CONSTRETE CARD BY FULL<br>TAG CONTINUED TO PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY MUST BE PRECEDED BY FULL<br>TAG CONTINUED TO THE APPROPRIATE<br>DEFICIENCY MUST BE PRECEDED BY THE TRANSPORTATION)<br>21620<br>21620<br>Continued From page 19<br>should be dated when opened and will removed<br>and reorder new ones.<br>On 2/3/16, at 10:30 a.m. the director of nursing<br>(DON) explained that staff were supposed to date<br>medication bottles and vials when opened. In<br>addition, the DON indicated that staff should<br>follow policies and pharmacy recommendations.<br>Undated Medication storage and expiration<br>guidelines, directed, "insulin 10 ML (milliliter) vials<br>opened - room temperature, 28 days after 1st<br>use, date when open yes. Xalatan eye drops<br>opened - room temperature, 45 days after 1st<br>use, date when open yes."<br>Policy and procedure titled EXPIRATION AND<br>BEYCOND-USE DATING, dated 1/27/15, reads,<br>"D. Certain medications have beyond-use dates<br>specified by the manufacturer that are dependent<br>on storage conditions and/or date of this use.<br>(see chart for example). Nursing staff will write  |           |   | 00803   | B. WING                          |   | 02                                   | 2/04/2016          |
| WOODBURY HEALTH CARE CENTER         WOODBURY, MN 55125           (X4) ID<br>PREFIX<br>TAG         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         ID<br>PREFIX<br>TAG         PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)         comPlete<br>DMTE           21620         Continued From page 19<br>should be dated when opened and will removed<br>and reorder new ones.         21620         Continued From page 19<br>should be dated when opened and will removed<br>and reorder new ones.         21620           On 2/3/16, at 10:30 a.m. the director of nursing<br>(DON) explained that staff were supposed to date<br>medication bottles and vials when opened. In<br>addition, the DON indicated that staff should<br>follow policies and pharmacy recommendations.         Indiated Medication storage and expiration<br>guidelines, directed, "insulin 10 ML (milliliter) vials<br>opened - room temperature, 28 days after 1st<br>use, date when open yes."         Vial and the tast of the tast of the tast<br>specified by the manufacturer that are dependent<br>on storage conditions have beyond-use dates<br>specified by the manufacturer that are dependent<br>on storage conditions and/or date of this use.<br>(see chart for example). Nursing staff will write  | NAME OF P | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STATE              | , ZIP CODE                                |                                      |                    |
| PREFX<br>TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX<br>TAG       (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCE) TO THE APPROPRIATE<br>DEFICIENCY)       COMPLET<br>DATE         21620       Continued From page 19       21620       21620       Image: Complete the appropriate of the approprise of the appropriate of the approprise of the approp                                 | NOODBU    | RY HEALTH CARE CEN  | TER   |                                  |   |                                      |                    |
| should be dated when opened and will removed<br>and reorder new ones.<br>On 2/3/16, at 10:30 a.m. the director of nursing<br>(DON) explained that staff were supposed to date<br>medication bottles and vials when opened. In<br>addition, the DON indicated that staff should<br>follow policies and pharmacy recommendations.<br>Undated Medication storage and expiration<br>guidelines, directed, "insulin 10 ML (milliliter) vials<br>opened - room temperature, 28 days after 1st<br>use, date when open yes. Xalatan eye drops<br>opened - room temperature, 45 days after 1st<br>use, date when open yes."<br>Policy and procedure titled EXPIRATION AND<br>BEYOND-USE DATING, dated 1/27/15, reads,<br>"D. Certain medications have beyond-use dates<br>specified by the manufacturer that are dependent<br>on storage conditions and/or date of this use.<br>(see chart for example). Nursing staff will write  | PREFIX    | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES   | ID<br>PREFIX                     | (EACH CORRECTIVE A<br>CROSS-REFERENCED TO | CTION SHOULD BE<br>O THE APPROPRIATE | COMPLET            |
| and reorder new ones.         On 2/3/16, at 10:30 a.m. the director of nursing<br>(DON) explained that staff were supposed to date<br>medication bottles and vials when opened. In<br>addition, the DON indicated that staff should<br>follow policies and pharmacy recommendations.         Undated Medication storage and expiration<br>guidelines, directed, "insulin 10 ML (milliliter) vials<br>opened - room temperature, 28 days after 1st<br>use, date when open yes. Xalatan eye drops<br>opened - room temperature, 45 days after 1st<br>use, date when open yes."         Policy and procedure titled EXPIRATION AND<br>BEYOND-USE DATING, dated 1/27/15, reads,<br>"D. Certain medications have beyond-use dates<br>specified by the manufacturer that are dependent<br>on storage conditions and/or date of this use.<br>(see chart for example). Nursing staff will write   | 21620     |   |   | 21620                            |   |                                      |                    |
|   |           | On 2/3/16, at 10:30 a<br>(DON) explained that<br>medication bottles ar<br>addition, the DON ind<br>follow policies and ph<br>Undated Medication<br>guidelines, directed,<br>opened - room tempe<br>use, date when open<br>opened - room tempe<br>use, date when open<br>Policy and procedure<br>BEYOND-USE DATII<br>"D. Certain medication<br>specified by the man<br>on storage conditions | a.m. the director of nursing<br>t staff were supposed to date<br>nd vials when opened. In<br>dicated that staff should<br>narmacy recommendations.<br>storage and expiration<br>"insulin 10 ML (milliliter) vials<br>erature, 28 days after 1st<br>yes. Xalatan eye drops<br>erature, 45 days after 1st<br>yes."<br>e titled EXPIRATION AND<br>NG, dated 1/27/15, reads,<br>ons have beyond-use dates<br>ufacturer that are dependent<br>s and/or date of this use. |                                  |   |                                      |                    |

| STATEMENT                | a Department of Healt<br>OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING: |   |                                    | E SURVEY<br>PLETED       |
|--------------------------|---|---|----------------------------------|---|------------------------------------|--------------------------|
|                          |   | 00803   | B. WING                          |   | 02                                 | 2/04/2016                |
| NAME OF PI               | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STATE,             | , ZIP CODE  |                                    |                          |
| WOODBU                   | RY HEALTH CARE CEN  | TER   | KE ROAD<br>URY, MN 55125         |   |                                    |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN C<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | CTION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| 21685                    | Continued From page   | e 20  | 21685                            |   |                                    |                          |
| 21685                    | MN Rule 4658.1415<br>Housekeeping, Oper   | Subp. 2 Plant<br>ation, & Maintenance   | 21685                            |   |                                    |                          |
|                          | including walls, floors<br>systems, and equipm<br>continuous state of g<br>with regard to the hea | ant. The physical plant,<br>s, ceilings, all furnishings,<br>nent must be kept in a<br>ood repair and operation<br>alth, comfort, safety, and<br>idents according to a written<br>and repair program. |                                  |   |                                    |                          |
|                          | by:<br>Based on observation<br>failed to ensure cupb  |   |                                  |   |                                    |                          |
|                          | Findings include:   |   |                                  |   |                                    |                          |
|                          | a.m. to 10:25 a.m. the kitchenette cabinets in  | en tour on 2/4/16, from 9:35<br>e wood finishes of lower<br>in the 3 North, 3 South, and<br>ited to be worn down to the<br>aces.  |                                  |   |                                    |                          |
|                          | -   | room the inside bottom of 3<br>orn down to the raw wood,<br>ncleanable.   |                                  |   |                                    |                          |
|                          | a.m. that maintenanc  | onal services stated at 10:05<br>e would look at the<br>bout having them cleaned  |                                  |   |                                    |                          |
|                          | The facility was unab maintenance schedu  | le to provide a preventative<br>le for the kitchenette  |                                  |   |                                    |                          |
|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO          |  |                                   | SURVEY                 |
|--------------------------|---|---|---------------------------|--|-----------------------------------|------------------------|
|                          |   |   | A. BUILDING:              |  |                                   |                        |
|                          |   | 00803   | B. WING                   |  | 02/04/201                         |                        |
| IAME OF PF               | ROVIDER OR SUPPLIER   | STREET A  | ADDRESS, CITY, STATE      | , ZIP CODE   |                                   |                        |
| VOODBU                   | RY HEALTH CARE CE   | NTER  | KE ROAD<br>SURY, MN 55125 |  |                                   |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |
| 21685                    | Continued From particular cabinets.   | ge 21   | 21685                     |  |                                   |                        |
|                          | administrator or des<br>kitchenette cabinets<br>refinished; and the i<br>drawers were refinis<br>surface. The admin<br>nursing, dietary, ma<br>housekeeping staff | nside of the kitchenette<br>shed to ensure a cleanable<br>strator could coordinate with<br>intenance and/or<br>to conduct periodic audits of<br>ensure the cabinets were kept |                           |  |                                   |                        |
|                          | TIME PERIOD FOR<br>days.  | CORRECTION: Thirty (30)   |                           |  |                                   |                        |
| 21695                    | MN Rule 4658.1415<br>Housekeeping, Ope  | 5 Subp. 4 Plant<br>eration, & Maintenance   | 21695                     |  |                                   |                        |
|                          | provide housekeepi<br>necessary to mainta<br>comfortable interior   | eping. A nursing home must<br>ng and maintenance services<br>ain a clean, orderly, and<br>, including walls, floors,<br>fxtures, equipment, lighting,                         |                           |  |                                   |                        |
|                          | by:<br>Based on observati<br>failed to ensure cup<br>6 kitchenettes were  | ent is not met as evidenced<br>on, and interview, the facility<br>boards and/or drawers in 4 of<br>kept clean. This had the<br>00 of 165 residents residing in                |                           |  |                                   |                        |
|                          | Findings include:   |   |                           |  |                                   |                        |

STATE FORM

|               | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CC<br>A. BUILDING: |   | (X3) DATE<br>COMF                    | SURVEY<br>PLETED |
|---------------|--|--|----------------------------------|---|--------------------------------------|------------------|
|               |  | 00803  |                                  |   | 00/01/0010                           |                  |
| AME OF PI     | ROVIDER OR SUPPLIER  |  | DDRESS, CITY, STATE,             |   | 02                                   | /04/2016         |
| /OODBU        | RY HEALTH CARE CEN   | ER   | KE ROAD                          |   |                                      |                  |
| (X4) ID       | SUMMARY ST   |  | URY, MN 55125                    | PROVIDER'S PLAN                                     |                                      | (X5)             |
| PREFIX<br>TAG | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                    | (EACH CORRECTIVE A<br>CROSS-REFERENCED T<br>DEFICIE | CTION SHOULD BE<br>O THE APPROPRIATE | COMPLE<br>DATE   |
| 21695         | Continued From page  | 22   | 21695                            |   |                                      |                  |
|               | a.m. to 10:25 a.m. the<br>3 North and 2 West u<br>down the front of the  | en tour on 2/4/16, from 9:35<br>e lower cabinet doors of the<br>nits had white spots/spills<br>doors.<br>oom the lower corners of 3  |                                  |   |                                      |                  |
|               | of 6 upper kitchenette<br>touch and a debris wa<br>touching the cabinet of<br>nutritional services to<br>cabinets, stated they | e cabinets were sticky to the<br>as noted on the fingers after<br>corners. The director of<br>uched the corners of the<br>were sticky and asked the<br>boom to clean the cabinets. |                                  |   |                                      |                  |
|               | a.m. that it was house   | onal services stated at 10:05<br>ekeeping's responsibility to<br>ne kitchenette cabinets.  |                                  |   |                                      |                  |
|               | The facility was unab<br>maintenance or clean<br>kitchenette cabinets.   | le to provide a preventative<br>ing schedule for the   |                                  |   |                                      |                  |
|               | administrator or desig<br>kitchenette cabinets v<br>administrator could co<br>dietary, maintenance                             | oordinate with nursing,<br>and/or housekeeping staff<br>udits of the kitchenettes to   |                                  |   |                                      |                  |
|               | TIME PERIOD FOR (<br>days.   | CORRECTION: Thirty (30)  |                                  |   |                                      |                  |
| 21710         | MN Rule 4658.1415 S<br>Housekeeping, Opera   |  | 21710                            |   |                                      |                  |

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO<br>A. BUILDING: |  |                                   | E SURVEY<br>PLETED      |
|--------------------------|---|--|----------------------------------|--|-----------------------------------|-------------------------|
|                          |   | 00803  | B. WING                          |  | 00/04/0040                        |                         |
|                          | ROVIDER OR SUPPLIER   |  | DDRESS, CITY, STATE,             | , ZIP CODE   | 02                                | 2/04/2016               |
|                          | RY HEALTH CARE CEN  | 7012 LA  | KE ROAD                          |  |                                   |                         |
|                          |   | WOODB  | URY, MN 55125                    |  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21710                    | Continued From page   | e 23   | 21710                            |  |                                   |                         |
|                          | supplied to sinks and maintained within a te  | emperature. Hot water<br>bathing fixtures must be<br>emperature range of 105<br>o115 degrees Fahrenheit at   |                                  |  |                                   |                         |
|                          | by:<br>Based on observatior<br>review, the facility fail<br>temperatures within a   | n, interview and document<br>led to maintain water<br>acceptable limits for 3 of 4<br>wed, rooms 118, 236 and  |                                  |  |                                   |                         |
|                          | Findings include:   |  |                                  |  |                                   |                         |
|                          | between 3:30 p.m. ar<br>maintenance supervis<br>water temperatures w<br>bathroom sinks, using<br>thermometer: room 1<br>Fahrenheit]; room 23<br>116.6 F. MS confirme<br>facility completed aud<br>rooms and provided a<br>MS reported the facili<br>120 F. MS reported h<br>system so water wou<br>115 F in resident roor | sor (MS). The following<br>vere noted in resident<br>g the facility water<br>18: 116.7 F [degrees<br>6: 117.1 F and room 319:<br>ed findings. MS reported the<br>dits for hot water in resident<br>a log for surveyor. However,<br>ity allowed an upper limit of<br>ne would adjust the hot water<br>Id reach an upper limit of<br>ms and bathrooms. |                                  |  |                                   |                         |
|                          | 3/12/15, directed staf<br>for all public areas, re  | ure Policy, last revised<br>f: "The water temperatures<br>esident rooms (including tubs<br>y in a range of 105 degrees<br>enheit."   |                                  |  |                                   |                         |
|                          |   | OD OF CORRECTION:<br>pervisor, administrator or  |                                  |  |                                   |                         |

|                          | F OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO<br>A. BUILDING: |   |                                      | E SURVEY<br>PLETED      |
|--------------------------|--|--|----------------------------------|---|--------------------------------------|-------------------------|
|                          |  | 00803  | B. WING                          |   | 02/04/2016                           |                         |
| NAME OF P                | ROVIDER OR SUPPLIER  |  | DDRESS, CITY, STATE              | , ZIP CODE  | 1 0-                                 |                         |
| WOODBU                   | RY HEALTH CARE CEN   | TER  | KE ROAD                          |   |                                      |                         |
|                          |  | WOODB  | URY, MN 55125                    |   |                                      |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN (<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED T(<br>DEFICIE | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21710                    | Continued From page  | e 24   | 21710                            |   |                                      |                         |
|                          | procedures related to<br>to sinks and bathing<br>a temperature range<br>to 115 degrees Fahre<br>maintenance supervi<br>designee could devel<br>and develop a monito<br>water supplied to sint<br>maintained within a to<br>degrees Fahrenheit to<br>the fixtures.  | w and revise policies and<br>o ensuring hot water supplied<br>fixtures is maintained within<br>of 105 degrees Fahrenheit<br>nheit at the fixtures.The<br>sor, administrator or<br>lop a system to educate staff<br>oring system to ensure hot<br>ks and bathing fixtures is<br>emperature range of 105<br>o115 degrees Fahrenheit at<br>CORRECTION: Twenty-one   |                                  |   |                                      |                         |
| 21825                    | MN St. Statute 144.6<br>Residents of HC Fac  | 51 Subd. 9 Patients &<br>.Bill of Rights   | 21825                            |   |                                      |                         |
|                          | complete and current<br>their diagnosis, treatr<br>prognosis as required<br>duty to disclose. This<br>terms and language to<br>be expected to under<br>accompanied by a fa<br>chosen representativ<br>shall include the likely<br>psychological results<br>alternatives. In cases<br>inadvisable, as docur<br>physician in a resider<br>information shall be o<br>guardian or other per<br>resident as a represe<br>right to refuse this inf | ven by their physicians<br>t information concerning<br>ment, alternatives, risks, and<br>d by the physician's legal<br>i information shall be in<br>the residents can reasonably<br>rstand. Residents may be<br>mily member or other<br>e, or both. This information<br>y medical or major<br>of the treatment and its<br>is where it is medically<br>mented by the attending<br>nt's medical record, the<br>given to the resident's<br>rson designated by the<br>entative. Individuals have the |                                  |   |                                      |                         |

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE C     |   |                                      | E SURVEY<br>PLETED      |
|--------------------------|---|---|---------------------|---|--------------------------------------|-------------------------|
|                          |   | 00803   | B. WING             |   | 02/04/2016                           |                         |
| NAME OF PI               | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STATE | , ZIP CODE  | 02                                   | ./04/2010               |
|                          |   | 7012 LA   | KE ROAD             |   |                                      |                         |
| WOODBU                   | RY HEALTH CARE CEN  | WOODB   | URY, MN 55125       |   |                                      |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN (<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED TO<br>DEFICIE | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21825                    | Continued From pag  | e 25  | 21825               |   |                                      |                         |
|                          | the time of admission<br>alternative effective r<br>which the treating ph<br>including surgical, ra<br>chemotherapeutic tre   | be fully informed, prior to or at<br>in and during her stay, of all<br>methods of treatment of<br>hysician is knowledgeable,<br>diological, or<br>eatments or combinations of<br>isks associated with each of   |                     |   |                                      |                         |
|                          | by:<br>Based on interview a<br>facility failed to obtain<br>R161's family decision<br>initiation of occupation  | nt is not met as evidenced<br>and document review, the<br>n informed consent from<br>on makers, (F)-A, prior to the<br>onal therapy for 1 of 1<br>r informed consent, (R161).   |                     |   |                                      |                         |
|                          |   | ost recent annual minimum<br>d 10/21/15, revealed R161<br>nitively impaired.  |                     |   |                                      |                         |
|                          | reported he was a de<br>health and financial r<br>reported he received<br>form which indicated<br>occupational therapy<br>November. F-A then<br>would get similar sta | 2/1/16, at 7:04 p.m., F-A<br>esignated decision maker for<br>matters for R161. F-A<br>I an explanation of benefit<br>I he owed over \$90 for<br>V (OT) for the month of<br>reported he found out he<br>tements for December and<br>ed he was not aware R161 |                     |   |                                      |                         |
|                          | was receiving occup<br>told by the facility to<br>that it was ending an   | ational therapy until he was<br>come down and sign a form<br>id received a form in the mail<br>bwe over \$90 for OT in  |                     |   |                                      |                         |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO<br>A. BUILDING: |   |                                   | E SURVEY<br>PLETED     |  |
|--------------------------|--|--|----------------------------------|---|-----------------------------------|------------------------|--|
|                          |  |  |                                  |   |                                   |                        |  |
|                          |  | 00803  | B. WING                          |   | 02                                | /04/2016               |  |
| AME OF PI                | ROVIDER OR SUPPLIER  |  | DDRESS, CITY, STATE              | , ZIP CODE  |                                   |                        |  |
| IOODBU                   | RY HEALTH CARE CEN   | TFR  | KE ROAD<br>URY, MN 55125         |   |                                   |                        |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |  |
| 21825                    | Continued From pag   | e 26   | 21825                            |   |                                   |                        |  |
|                          | the extent of services<br>it would be several s<br>November, December<br>he would want to be<br>any rehabilitation ser-<br>had told the facility th<br>occurred about a year<br>needed rehabilitation<br>have it, but he wanter<br>make that determina<br>On 2/3/16, at 12:48 p<br>rehabilitation therapy<br>just informed after R<br>or so ago that F-A ha<br>not being fully inform<br>OT. DRT reported R<br>improve self feeding<br>December and Januar<br>rehabilitation therapy<br>informed consent for | er and January. F-A reported<br>fully informed in advance of<br>rvices prior to initiation and<br>his after a similar incident<br>ar prior. F-A reported if R161<br>in therapy, he wanted her to<br>ed enough information to<br>tion.<br>b.m. the director of<br>( DRT) explained she was<br>161's care conference a day<br>ad expressed concerns about<br>led about R161's receiving<br>161 received OT services to   |                                  |   |                                   |                        |  |
|                          | resident decision mare<br>rehabilitation therapy<br>had recently discuss<br>learning of F-A's con-<br>documented. DRT re-<br>rehabilitation therapy<br>getting informed con-<br>services. There was<br>ensure informed con-<br>the start of rehabilitat<br>to her knowledge, F-<br>funds to pay the co-por-<br>OT services, even the<br>not obtained. A polici   | sent from the resident or the<br>ikers prior to the start of<br>a services. DRT reported she<br>ed this with her staff after<br>cern. However, this was not<br>eported she discovered<br>a staff were not routinely<br>sent prior to starting<br>no formal process in place to<br>sent was obtained prior to<br>tion services. DRT reported,<br>A still needed to use R161's<br>pay of over \$90 for R161's<br>rough informed consent was<br>y on obtaining informed<br>uting rehabilitation therapy |                                  |   |                                   |                        |  |

| STATEMEN                 | ta Department of Healt<br>T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CO<br>A. BUILDING: |  |                                   | E SURVEY<br>PLETED      |
|--------------------------|--|---|----------------------------------|--|-----------------------------------|-------------------------|
|                          |  | 00803   | B. WING                          |  | 02/04/2016                        |                         |
| NAME OF P                | ROVIDER OR SUPPLIER  |   | DDRESS, CITY, STATE              | , ZIP CODE   |                                   |                         |
| WOODBU                   | IRY HEALTH CARE CEN  | 7012 LA   | KE ROAD                          |  |                                   |                         |
| WOODBU                   |  | WOODB   | URY, MN 55125                    |  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN OI<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21825                    | Continued From pag   | e 27  | 21825                            |  |                                   |                         |
|                          | services was reques  | ted but not provided.   |                                  |  |                                   |                         |
|                          | 2/4/16, revealed F-A<br>maker for R161's fina<br>Another family member<br>emergency contact, I<br>Review of R161's OT<br>Progress and Update<br>Therapist Progress a<br>dated 11/10/15 to 1/2<br>received OT services    | but not a decision maker.<br>F Plan of Care, Therapist<br>ed Plan of Care and<br>and Discharge Summary,<br>18/16 revealed R161<br>s to improve self feeding   |                                  |  |                                   |                         |
|                          | undated revealed a h<br>See attached therapy<br>will be more for Dec<br>when therapy is prov<br>surprise! [F-A-phone<br>Explanation of Beneficiarity of Beneficiarity<br>claims for OT service<br>11/23/15. R161 was     | n and/or Questions Form,<br>nand written note: "Therapy:<br>y charge understand there<br>and Jan-Please let me know<br>vided in the future. This is a<br>number]. Attached was an<br>fits, dated 1/9/16 with 10<br>es between 11/10/15 and<br>responsible for paying<br>vices. A handwritten note                                     |                                  |  |                                   |                         |
|                          | effective 11/10/15 un<br>noted "Treatment Pla<br>and alternatives disc<br>family, who agree to<br>note did not indicate<br>informed consent an<br>received. The note of<br>informed consent fro<br>decision maker for he | T care plan, dated 11/10/15,<br>itil 12/7/15. The OT care plan<br>an, including benefits, risks<br>ussed with patient and/or<br>treatment." However, the<br>the individual that gave<br>d the date and time it was<br>did not indicate OT obtained<br>m R161's designated<br>ealthcare and financial<br>note did not indicate how F-A |                                  |  |                                   |                         |

|                          | FOF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CO<br>A. BUILDING: |  |                                      | E SURVEY<br>PLETED      |  |
|--------------------------|---|--|----------------------------------|--|--------------------------------------|-------------------------|--|
|                          |   | 00000  |                                  | B. WING  |                                      |                         |  |
| AME OF P                 | ROVIDER OR SUPPLIER   | 00803  | DDRESS, CITY, STATE,             |  | 02                                   | /04/2016                |  |
|                          | RY HEALTH CARE CEN  | 7012 LA  | KE ROAD<br>URY, MN 55125         |  |                                      |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN C<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED TC<br>DEFICIEI | CTION SHOULD BE<br>D THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 21825                    | Continued From pag<br>benefits and alternat<br>benefits and alternat<br>ensure it was in a ma<br>There was no docum<br>given updates on up<br>12/8/15, 12/28/15 an<br>11/10/15 and ending<br>SUGGESTED METH<br>The administrator, di<br>could review and/or of<br>procedure regarding<br>education to staff pro-<br>policy and procedure<br>consent. The administ<br>designee would initia<br>compliance. | e 28<br>ives and what plan, risks,<br>ives were discussed to<br>anner F-A could understand.<br>nentation indicating F-A was<br>dated plans of care, dated<br>d 1/18/16 since initiation on | 21825                            |  |                                      |                         |  |

| Minnesc                  | ta Department of He  | alth  |                      |  |                   |                          |
|--------------------------|--|---|----------------------|--|-------------------|--------------------------|
| -                        | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                  | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|                          |  | 00803   | B. WING              |  | 02/0              | 4/2016                   |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S       | STATE, ZIP CODE  |                   |                          |
| WOODB                    | URY HEALTH CARE (  | CENTER 7012 LAK WOODBU  | E ROAD<br>RY, MN 551 | 25   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Initial Comments   |   | 2 000                |  |                   |                          |
|                          | *****ATTEI   | NTION*****  |                      |  |                   |                          |
|                          | NH LICENSING   | CORRECTION ORDER  |                      |  |                   |                          |
|                          | 144A.10, this correct<br>pursuant to a surve<br>found that the defic<br>herein are not corrected shall   | Minnesota Statute, section<br>ction order has been issued<br>y. If, upon reinspection, it is<br>iency or deficiencies cited<br>ected, a fine for each violation<br>be assessed in accordance<br>ines promulgated by rule of<br>artment of Health.   |                      |  |                   |                          |
|                          | corrected requires of<br>requirements of the<br>number and MN Ru<br>When a rule contain<br>comply with any of<br>lack of compliance.<br>re-inspection with a<br>result in the assess | hether a violation has been<br>compliance with all<br>rule provided at the tag<br>ile number indicated below.<br>Ins several items, failure to<br>the items will be considered<br>Lack of compliance upon<br>ny item of multi-part rule will<br>ment of a fine even if the item<br>uring the initial inspection was |                      |  |                   |                          |
|                          | that may result from<br>orders provided tha<br>the Department with   | hearing on any assessments<br>n non-compliance with these<br>t a written request is made to<br>hin 15 days of receipt of a<br>nt for non-compliance.  |                      |  |                   |                          |
|                          | receipt of State lice<br>the Minnesota Depa<br>Informational Bullet<br>http://www.health.st<br>obul.htm The Stat<br>delineated on the a  | participate in the electronic<br>nsure orders consistent with<br>artment of Health<br>in 14-01, available at<br>tate.mn.us/divs/fpc/profinfo/inf<br>e licensing orders are  |                      |  |                   |                          |
| ABORATOR                 | epartment of Health<br>Y DIRECTOR'S OR PROVIE<br>ically Signed   | ER/SUPPLIER REPRESENTATIVE'S SIGI   | NATURE               | TITLE  |                   | (X6) DATE<br>02/25/16    |

If continuation sheet 1 of 29

| (EACH DEFICIENC   | CENTER 7012 LA<br>WOODE   | B. WING   |   | 02/   | 04/2016   |
|---|---|---|---|---|---|
| IRY HEALTH CARE<br>SUMMARY ST/<br>(EACH DEFICIENC   | CENTER 7012 LA<br>WOODE   |   |   |   |   |
| SUMMARY STA<br>(EACH DEFICIENC  | CENTER WOODE  |   | TATE, ZIP CODE  |   |   |
| (EACH DEFICIENC   |   | BURY, MN 5512   | 25  |   |   |
| REGULATORY OR L   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | N SHOULD BE   | (X5)<br>COMPLET<br>DATE   |
| you electronically.<br>is necessary for St<br>enter the word "con<br>text. You must ther<br>State licensure pro<br>completion date, th<br>corrected prior to end<br>Minnesota Departr<br>On February 1, 2, 3<br>Department's staff,<br>the following correct<br>Please indicate in y<br>correction that you<br>and identify the dat<br>Minnesota Departr<br>the State Licensing<br>federal software. The<br>assigned to Minnes<br>Nursing Homes.<br>The assigned tag r<br>column entitled "IE<br>statute/rule out of co<br>"Summary Stateme<br>and replaces the " | alth orders being submitted to<br>Although no plan of correction<br>ate Statutes/Rules, please<br>rrected" in the box available for<br>indicate in the electronic<br>breess, under the heading<br>he date your orders will be<br>electronically submitting to the<br>nent of Health.<br>3, 4, 2016, surveyors of this<br>, visited the above provider and<br>ction orders are issued.<br>your electronic plan of<br>have reviewed these orders,<br>te when they will be completed<br>nent of Health is documenting<br>g Correction Orders using<br>ag numbers have been<br>sota state statutes/rules for<br>humber appears in the far left<br>D Prefix Tag." The state<br>compliance is listed in the<br>ent of Deficiencies" column<br>To Comply" portion of the | r<br>d  |   |   |   |
| after the statement<br>evidence by." Follo<br>are the Suggested<br>Time period for Co<br>PLEASE DISREGA<br>FOURTH COLUMI  | t, "This Rule is not met as<br>wing the surveyors findings<br>Method of Correction and<br>rrection.<br>ARD THE HEADING OF THE<br>N WHICH STATES,  |   |   |   |   |
| etsool olthoa ltfal - os'aofaea- ll'y-  | enter the word "con<br>text. You must ther<br>State licensure pro-<br>completion date, the<br>corrected prior to e<br>Minnesota Departr<br>On February 1, 2, 3<br>Department's staff<br>the following correc<br>Please indicate in y<br>correction that you<br>and identify the dat<br>Minnesota Departr<br>the State Licensing<br>ederal software. T<br>assigned to Minnes<br>Nursing Homes.<br>The assigned tag r<br>column entitled "II<br>statute/rule out of of<br>Summary Statement<br>existence by." Follo<br>and replaces the "<br>correction order. T<br>indings which are<br>after the statement<br>evidence by." Follo<br>are the Suggested<br>Time period for Co<br>PLEASE DISREG/<br>OURTH COLUMI<br>'PROVIDER'S PL/<br>APPLIES TO FED               | enter the word "corrected" in the box available for<br>text. You must then indicate in the electronic<br>State licensure process, under the heading<br>completion date, the date your orders will be<br>corrected prior to electronically submitting to the<br>Minnesota Department of Health.<br>On February 1, 2, 3, 4, 2016, surveyors of this<br>Department's staff, visited the above provider an<br>the following correction orders are issued.<br>Please indicate in your electronic plan of<br>correction that you have reviewed these orders,<br>and identify the date when they will be completed<br>Minnesota Department of Health is documenting<br>the State Licensing Correction Orders using<br>federal software. Tag numbers have been<br>assigned to Minnesota state statutes/rules for<br>Nursing Homes.<br>The assigned tag number appears in the far left<br>column entitled "ID Prefix Tag." The state<br>statute/rule out of compliance is listed in the<br>'Summary Statement of Deficiencies" column<br>and replaces the "To Comply" portion of the<br>correction order. This column also includes the<br>indings which are in violation of the state statute<br>after the statement, "This Rule is not met as<br>evidence by." Following the surveyors findings<br>are the Suggested Method of Correction and<br>Time period for Correction.<br>PLEASE DISREGARD THE HEADING OF THE<br>FOURTH COLUMN WHICH STATES,<br>'PROVIDER'S PLAN OF CORRECTION." THIS<br>APPLIES TO FEDERAL DEFICIENCIES ONLY.<br>THIS WILL APPEAR ON EACH PAGE. | enter the word "corrected" in the box available for<br>rext. You must then indicate in the electronic<br>State licensure process, under the heading<br>completion date, the date your orders will be<br>corrected prior to electronically submitting to the<br>Minnesota Department of Health.<br>On February 1, 2, 3, 4, 2016, surveyors of this<br>Department's staff, visited the above provider and<br>the following correction orders are issued.<br>Please indicate in your electronic plan of<br>correction that you have reviewed these orders,<br>and identify the date when they will be completed.<br>Minnesota Department of Health is documenting<br>the State Licensing Correction Orders using<br>federal software. Tag numbers have been<br>assigned to Minnesota state statutes/rules for<br>Nursing Homes.<br>The assigned tag number appears in the far left<br>column entitled "ID Prefix Tag." The state<br>statute/rule out of compliance is listed in the<br>'Summary Statement of Deficiencies" column<br>and replaces the "To Comply" portion of the<br>correction order. This column also includes the<br>indings which are in violation of the state statute<br>after the statement, "This Rule is not met as<br>avidence by." Following the surveyors findings<br>are the Suggested Method of Correction and<br>Time period for Correction.<br>PLEASE DISREGARD THE HEADING OF THE<br>FOURTH COLUMN WHICH STATES,<br>'PROVIDER'S PLAN OF CORRECTION." THIS<br>APPLIES TO FEDERAL DEFICIENCIES ONLY.<br>THIS WILL APPEAR ON EACH PAGE. | enter the word "corrected" in the box available for<br>rext. You must then indicate in the electronic<br>State licensure process, under the heading<br>completion date, the date your orders will be<br>corrected prior to electronically submitting to the<br>Minnesota Department of Health.<br>On February 1, 2, 3, 4, 2016, surveyors of this<br>Department's staff, visited the above provider and<br>he following correction orders are issued.<br>Please indicate in your electronic plan of<br>correction that you have reviewed these orders,<br>and identify the date when they will be completed.<br>Minnesota Department of Health is documenting<br>the State Licensing Correction Orders using<br>'ederal software. Tag numbers have been<br>assigned to Minnesota state statutes/rules for<br>Nursing Homes.<br>The assigned tag number appears in the far left<br>column entitled "ID Prefix Tag." The state<br>statute/rule out of compliance is listed in the<br>'Summary Statement of Deficiencies" column<br>and replaces the "To Comply" portion of the<br>correction order. This column also includes the<br>indings which are in violation of the state statute<br>after the statement, "This Rule is not met as<br>sevidence by." Following the surveyors findings<br>are the Suggested Method of Correction and<br>Time period for Correction.<br>PLEASE DISREGARD THE HEADING OF THE<br>FOURTH COLUMN WHICH STATES,<br>'PROVIDER'S PLAN OF CORRECTION." THIS<br>APPLIES TO FEDERAL DEFICIENCIES ONLY.<br>THIS WILL APPEAR ON EACH PAGE. | anter the word "corrected" in the box available for<br>ext. You must then indicate in the electronic<br>State licensure process, under the heading<br>completion date, the date your orders will be<br>corrected prior to electronically submitting to the<br>Winnesota Department of Health.<br>On February 1, 2, 3, 4, 2016, surveyors of this<br>Department's staff, visited the above provider and<br>the following correction orders are issued.<br>Please indicate in your electronic plan of<br>correction that you have reviewed these orders,<br>and identify the date when they will be completed.<br>Winnesota Department of Health is documenting<br>the State Licensing Correction Orders using<br>ederal software. Tag numbers have been<br>assigned to Minnesota state statutes/rules for<br>Nursing Homes.<br>The assigned tag number appears in the far left<br>column entitled "ID Prefix Tag." The state<br>statute/rule out of compliance is listed in the<br>'Summary Statement of Deficiencies" column<br>and replaces the "To Comply" portion of the<br>correction order. This column also includes the<br>indings which are in violation of the state statute<br>after the statement, "This Rule is not met as<br>svidence by." Following the surveyors findings<br>are the Suggested Method of Correction and<br>Time period for Correction.<br>PLEASE DISREGARD THE HEADING OF THE<br>FOURTH COLUMN WHICH STATES,<br>"PROVIDER'S PLAN OF CORRECTION." THIS<br>APPLIES TO FEDERAL DEFICIENCIES ONLY.<br>THIS WILL APPEAR ON EACH PAGE. |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                       |   | E SURVEY<br>IPLETED     |
|--------------------------|---|---|-----------------------|---|-------------------------|
|                          |   | 00803   | B. WING               |   | /04/2016                |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY,         | STATE, ZIP CODE   |                         |
| WOODB                    | URY HEALTH CARE   | CENTER  | KE ROAD<br>URY, MN 55 | 125   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLET<br>DATE |
| 2 000                    | Continued From pa   | age 2   | 2 000                 |   |                         |
|                          | PLAN OF CORRE   | QUIREMENT TO SUBMIT A<br>CTION FOR VIOLATIONS OF<br>E STATUTES/RULES.   |                       |   |                         |
| 2 560                    | MN Rule 4658.040<br>Plan of Care; Cont  | 5 Subp. 2 Comprehensive<br>ents   | 2 560                 |   | 3/15/16                 |
|                          | comprehensive pla<br>objectives and time<br>long- and short-tern<br>and mental and ps<br>identified in the cor<br>assessment. The<br>must include the in  | of plan of care. The<br>an of care must list measurable<br>etables to meet the resident's<br>m goals for medical, nursing,<br>ychosocial needs that are<br>nprehensive resident<br>comprehensive plan of care<br>dividual abuse prevention plan<br>sota Statutes, section 626.557,<br>agraph (b).   |                       |   |                         |
|                          | by:<br>Based on observat<br>review, the facility f<br>of hand contracture<br>residents reviewed<br>Findings include:<br>R181's most recen<br>data set [MDS], a s<br>completed on 9/16<br>functional impairme<br>in both upper extre<br>MDS revealed no f<br>of motion in the up<br>MDS revealed R18 | ent is not met as evidenced<br>ion, interview and document<br>failed to identify the presence<br>es in the care plan for 1 of 2<br>for range of motion, (R181).<br>t comprehensive minimum<br>significant change assessment<br>/15, revealed R181 had<br>ent in range of motion (ROM)<br>mities. The 12/9/15, quarterly<br>unctional impairment in range<br>per extremities. The 12/9/15,<br>81 had short and long term<br>and significant impairment in<br>pility. |                       | The preparation of the following plan of<br>correction of this deficiency does not<br>constitute and should not be interpreted a<br>an admission nor an agreement by the<br>facility of the truth of the facts alleged on<br>conclusions set forth in the statement of<br>deficiencies. The plan of correction<br>prepared for this deficiency was executed<br>solely because it is required by provisions<br>of State of Law. Without waiving the<br>forgoing statement, the facility states that:<br>1. With respect to resident R181 the care<br>plan was revised regarding the resident's<br>contractures and interventions as<br>indicated.<br>2. All residents with contractures will have<br>there care plans reviewed to assure the<br>contractures have been addressed along |                         |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPI<br>A. BUILDING        | LE CONSTRUCTION   | (X3) DATE<br>COMPI   |                        |
|--------------------------|--|--|------------------------------------|---|--|------------------------|
|                          |  | 00803  | B. WING                            |   | 02/04/2016   |                        |
| AME OF P                 | ROVIDER OR SUPPLIER  | STREET AI  | DRESS, CITY,                       | STATE, ZIP CODE   |  |                        |
| VOODBL                   | JRY HEALTH CARE (  | CENTER   | KE ROAD<br>URY, MN 55 <sup>°</sup> | 125   |  |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TH<br>DEFICIENCY   | ON SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLE<br>DATE |
| 2 560                    | Continued From pa  | age 3  | 2 560                              |   |  |                        |
|                          | On 2/2/16, at 11:19<br>manager, (RN)-B, r<br>contracture in her h<br>range of motion se<br>device in place.<br>On 2/3/16, at 1:43 p<br>observations of R1<br>attempted to uncur<br>contracted with fing<br>said "ouch" and RN<br>uncurl R181's hand<br>On 2/3/16, at 1:43 p<br>was responsible for<br>care plan reviewed<br>R181's contracture<br>reported it was dete<br>benefit from range<br>device due to it not<br>her significantly at a<br>almost all cares for<br>developed the cont<br>the facility. RN-B at<br>any documentation<br>to the facility's inter<br>making process to<br>splint services for F<br>appropriate goals a<br>R181's left hand co<br>was unsure if the m<br>dated 12/9/15, shor<br>functional impairme<br>A review of R181's<br>12/15/15, revealed<br>contracture was ad | <ul> <li>a.m. the registered nurse unit<br/>reported R181 had a<br/>nand and was not receiving<br/>rvices and did not have a splint</li> <li>p.m. surveyor made<br/>81 with RN-B. RN-B gently<br/>I R181's left hand, which was<br/>gers in toward the palm. R181<br/>I-B stopped attempting to<br/>d.</li> <li>p.m. RN-B and RN-C, who<br/>r completion of the MDS and<br/>R181's care plan and reported<br/>s were not addressed. RN-B<br/>ermined R181 would not<br/>of motion services or a splint<br/>causing her pain or impairing<br/>this point since staff provided<br/>R181. RN-B reported R181<br/>racture in August after a fall at<br/>nd RN-C were unable to find<br/>in the medical record related<br/>disciplinary team decision<br/>not pursue range of motion or<br/>R181 and what were<br/>and interventions related to<br/>ontracture. RN-C reported she<br/>nost recent quarterly MDS,<br/>uld have indicated no</li> </ul> | t                                  | with the appropriate interv<br>3. All licensed nursing star<br>re-educated by March 15,<br>revisions to care plans who<br>condition occurs.<br>4. The Director of Nursing<br>designee will audit 5 resid<br>each week for one month<br>resident care plans a wee<br>to assure care plans are a<br>reflect resident conditions<br>5. The data collected will the<br>QAPI by the Director of Ne<br>will be reviewed/discussed<br>decision/recommendation<br>regarding any necessary for | ff will be<br>2016 regarding<br>en a change of<br>and/or<br>ent care plans<br>and then 3<br>k for two months<br>accurate and<br>be presented at<br>ursing. The data<br>d and<br>s made |                        |
|                          |  |  | 11                                 | 1   |  |                        |

|                          | NT OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                                    | LE CONSTRUCTION (X  | 3) DATE SURVEY<br>COMPLETED                     |
|--------------------------|---|---|------------------------------------|---|---|
|                          |   | 00803   | B. WING                            |   | 02/04/2016                                      |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY,                      | STATE, ZIP CODE   |   |
| WOODB                    | URY HEALTH CARE (   | CENTER  | KE ROAD<br>URY, MN 55 <sup>.</sup> | 125   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  |   |
| 2 560                    | Continued From pa<br>Limitations in ROM   | -   | 2 560                              |   |   |
|                          | The director of nurs<br>staff to develop a c<br>interventions for all<br>monitoring program<br>to assure ongoing a<br>interventions in res  | THOD OF CORRECTION:<br>sing or designee could direct<br>are plan to include appropriate<br>identified care needs. A<br>n could be established in order<br>and effective care plan<br>ponse to resident care needs.<br>R CORRECTION: Twenty-one  |                                    |   |   |
| 2 565                    | Plan of Care; Use<br>Subp. 3. Use. A co   | 5 Subp. 3 Comprehensive<br>omprehensive plan of care<br>I personnel involved in the<br>t.   | 2 565                              |   | 3/15/16   |
|                          | by:<br>Based on observative review, the facility for the provision of active residents (R105) decompletion of ADL's Findings include:<br>The care plan revision had cognitive loss, judgement, decision processes. The care plan revison processes. | ent is not met as evidenced<br>ion, interview and document<br>ailed to follow the care plan for<br>ivities of daily living for 1 of 3<br>ependent on staff for<br>s.<br>eed on 4/11/14, revealed R105<br>with deficits in memory,<br>n making and thought<br>re plan directed staff R105<br>with cares and required one |                                    | The preparation of the following plan<br>correction of this deficiency does not<br>constitute and should not be interpre-<br>an admission nor an agreement by t<br>facility of the truth of the facts alleger<br>conclusions set forth in the statemen<br>deficiencies. The plan of correction<br>prepared for this deficiency was exer-<br>solely because it is required by provi<br>of State of Law. Without waiving the<br>forgoing statement, the facility states<br>1. With respect to R105, the Nurse | ted as<br>ne<br>d on<br>it of<br>cuted<br>sions |

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If continuation sheet 5 of 29

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                      | LE CONSTRUCTION   | (X3) DATE S<br>COMPL   |                         |
|--------------------------|---|---|----------------------|---|--|-------------------------|
|                          |   | 00803   | B. WING              |   | 02/04  | 4/2016                  |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY,         | STATE, ZIP CODE   |  |                         |
| WOODB                    | URY HEALTH CARE   | CENTER 7012 LAK<br>WOODBU   | E ROAD<br>IRY, MN 55 | 125   |  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | D BE   | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa   | age 5   | 2 565                |   |  |                         |
|                          | The care plan did r<br>chin whiskers.<br>On 2/1/16, at 5:45<br>inch long hairs wer<br>and corners of the<br>still present on 2/2/<br>8:26 a.m.; and on 2<br>On 2/4/16, at 8:59<br>stated R105 had a<br>but NA-Z had not g<br>NA-Z state R105 h<br>assignment list for<br>attempted to remov<br>dates. NA-Z stated<br>shaved but would t<br>today if the residen<br>the presence of the<br>The facility's policy<br>Program, dated 4/1<br>maintenance progr<br>assist to maintain a<br>level of function an<br>included the provis | a.m. nursing assistant (NA)-Z<br>bath on Saturday evenings,<br>jiven R105 a bath that evening.  |                      | Manager is working with the staff t<br>develop a routine for grooming the<br>resident, re-approaching or obtain<br>assistance of the nurse when resid<br>refuses. The resident care plan ar<br>nursing assistant assignment shee<br>been updated accordingly.<br>2. All residents have been reviewer<br>refusal of grooming and a plan of<br>established for approaches to prot<br>routine for shaving that best meets<br>residents needs. The NAR assign<br>sheet and resident care plan have<br>revised as indicated.<br>3. All nursing staff will receive edu<br>by March 15, 2016 regarding man<br>challenges during grooming and<br>interventions/approaches to ensur<br>individuals needs are met.<br>4. The Director of Nursing and/or<br>designee will audit 5 resident care<br>each week for one month and 3 re<br>care plans each week for 2 month<br>assure care plans have been revis<br>reflect any resident changes.<br>5. The data collected will be prese<br>QAPI by the Director of Nursing. T<br>will be reviewed/discussed and<br>decision/recommendations made<br>regarding any necessary follow up | e<br>ing the<br>dent<br>dent<br>d<br>ed for<br>care<br>mote a<br>s the<br>ment<br>been<br>cation<br>aging<br>re each<br>plans<br>esident<br>s to<br>sed to<br>ented at<br>the data |                         |
|                          | resident care plans<br>an accurate reflect<br>the resident. Nursin<br>on ensuring care w<br>accordance with ea<br>of care plans and c   | or designee should review<br>s to ensure the care plans were<br>ion of the services required by<br>ng staff could then be educated<br>vas provided to residents in<br>ach resident's care plan. Audits<br>observation of cares could be<br>re care was provided according |                      |   |  |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                                    | LE CONSTRUCTION   | (X3) DATE<br>COMP   | SURVEY<br>LETED         |
|--------------------------|---|---|------------------------------------|---|---|-------------------------|
|                          |   | 00803   | B. WING                            |   | 02/0  | 4/2016                  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AL   | DDRESS, CITY,                      | STATE, ZIP CODE   |   |                         |
| WOODB                    | URY HEALTH CARE   | CENTER  | KE ROAD<br>URY, MN 55 <sup>.</sup> | 125   |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | ULD BE  | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa   | age 6   | 2 565                              |   |   |                         |
|                          | to the care plan.   |   |                                    |   |   |                         |
|                          | TIME PERIOD FO<br>(14) days.  | R CORRECTION: Fourteen  |                                    |   |   |                         |
| 2 570                    | MN Rule 4658.040<br>Plan of Care; Revis   | 5 Subp. 4 Comprehensive<br>sion   | 2 570                              |   |   | 3/15/16                 |
|                          | care must be review<br>interdisciplinary tea<br>physician, a register<br>for the resident, an<br>disciplines as deter<br>and, to the extent<br>participation of the<br>guardian or chosen<br>quarterly and within   | A comprehensive plan of<br>wed and revised by an<br>in that includes the attending<br>ered nurse with responsibility<br>d other appropriate staff in<br>rmined by the resident's needs,<br>practicable, with the<br>resident, the resident's legal<br>n representative at least<br>n seven days of the revision of<br>e resident assessment required<br>subpart 3, item B.                |                                    |   |   |                         |
|                          | by:<br>Based on observat<br>review, the facility f<br>was revised for 1 o<br>limited range of mo<br>Findings include:<br>On 2/2/16, at 9:26<br>sitting in a Broda ch<br>clenched together i<br>devices were noted<br>nearby. On 2/3/16,<br>observed holding a<br>independently dram | ent is not met as evidenced<br>ion, interview and record<br>failed to ensure the care plan<br>f 3 residents (R105) with a<br>otion.<br>a.m. R105 was observed<br>hair with both hands lightly<br>in a fist. No splints or other<br>d in the resident's hands or<br>at 8:26 a.m. R105 was<br>glass in the right hand and<br>k from the glass. R105 was<br>se the left hand, pointer finger |                                    | The preparation of the following<br>correction of this deficiency doe<br>constitute and should not be int<br>an admission nor an agreement<br>facility of the truth of the facts a<br>conclusions set forth in the state<br>deficiencies. The plan of correc<br>prepared for this deficiency was<br>solely because it is required by<br>of State of Law. Without waiving<br>forgoing statement, the facility s<br>1. With respect to R105, the ca<br>was revised regarding the resid<br>limited ROM and interventions a | s not<br>erpreted as<br>by the<br>leged on<br>ement of<br>tion<br>executed<br>provisions<br>the<br>tates that:<br>re plan<br>ents |                         |

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If continuation sheet 7 of 29

|                          | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION  | (X3) DATE<br>COMP   | SURVEY<br>LETED        |
|--------------------------|---|--|---------------------|--|---|------------------------|
|                          |   | 00803  | B. WING             |  | 02/0  | 4/2016                 |
| AME OF F                 | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY,        | STATE, ZIP CODE  |   |                        |
|                          | URY HEALTH CARE   | CENTER 7012 LAP  | -                   |  |   |                        |
|                          |   | WOODBU   | JRY, MN 55          |  |   |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY)  | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLE<br>DATE |
| 2 570                    | Continued From pa   | age 7  | 2 570               |  |   |                        |
|                          | open the hand. The<br>R105's left hand.<br>On 2/2/16, at 9:14<br>stated the facility h<br>in the past and R10<br>away.<br>On 2/3/16, at 3:32<br>put cloths in R105's<br>this time there were<br>and was asked abor<br>R105's left hand. F<br>hospice at one time<br>want ROM or anyth<br>pain; and ROM to R<br>On 2/4/16, at 8:57<br>stated R105 would<br>hands, and did not<br>hands were washe<br>ROM to the left han<br>allow it. NA-Z state | However, R105 did not entirely<br>ere was no splint or cloth in<br>a.m. registered nurse (RN)-B<br>as tried hand splints for R105<br>05 would remove them right<br>p.m. RN-B stated staff would<br>s hands. RN-B was informed at<br>e no cloths in R105's hands,<br>but range of motion (ROM) to<br>RN-B stated R105 had been on<br>e and the hospice staff did not<br>hing which would cause R105<br>R105's had was "very painful."<br>a.m. nursing assistant (NA)-Z<br>allow staff to wash R105's<br>complain of pain when the<br>d. NA-Z stated that gentle<br>ind during cares if R105 would<br>ad R105 would not allow a cloth<br>nd, as staff had tried that and<br>e the cloth. |                     | <ul> <li>indicated.</li> <li>2. All residents with contract<br/>there care plans reviewed in<br/>contractures have been ad<br/>with the appropriate interverse.</li> <li>3. All licensed staff will be in<br/>March 15, 2016 regarding in<br/>care plans with any change<br/>orders.</li> <li>4. The Director of Nursing in<br/>designee will audit 5 reside<br/>each week for one month and<br/>care plans each week for 2<br/>assure care plans have been<br/>reflect any resident change<br/>5. The data collected will be<br/>QAPI by the Director of Nur<br/>will be reviewed/discussed<br/>decision/recommendations<br/>regarding any necessary for</li> </ul> | to assure the<br>dressed along<br>ention.<br>re-educated by<br>revisions to<br>a in status and<br>and/or<br>int care plans<br>and 3 resident<br>months to<br>en revised to<br>is.<br>e presented at<br>rsing. The data<br>and<br>made |                        |
|                          | 4/11/14, indicated I<br>tight, didn't extend<br>purposefully; had r<br>(OT) services; refu<br>caused increased a<br>were to complete r  | are plan dated/revised on<br>R105 would hold both hands<br>all digits consistently or<br>eceived occupational therapy<br>sed to wear splints, as they<br>agitation; and nursing staff<br>ecommendations from OT,<br>the care plan had been<br>4.   |                     |  |   |                        |
|                          | 2/3/16, at 3:32 p.m   | n was reviewed with RN-B on<br>. and RN-B was asked why the<br>ddress putting a cloth in   |                     |  |   |                        |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           |  | ATE SURVEY<br>OMPLETED  |
|--------------------------|---|--|---------------------------|--|-------------------------|
|                          |   | 00803  | B. WING                   | c  | 2/04/2016               |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET   | ADDRESS, CITY, S          | TATE, ZIP CODE   |                         |
| VOODB                    | URY HEALTH CARE   | CENTER   | AKE ROAD<br>BURY, MN 5512 | 25   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLET<br>DATE |
| 2 570                    | Continued From pa   | age 8  | 2 570                     |  |                         |
|                          | the cloths out. RN-   | that the resident would take<br>B stated the hospice care pla<br>I was not to be completed.  | IN                        |  |                         |
|                          | reviewed and indic  | blan dated 12/8/14, was<br>ated passive ROM was to be<br>ties, except the right arm,<br>red ulna.  |                           |  |                         |
|                          | and revised 8/13, in  | titled Care Plan Completion<br>ndicated a resident's care pla<br>/revised as changes occur.  | n                         |  |                         |
|                          | director of nurse or<br>revise the care plat<br>range of motion to                    | THOD OF CORRECTION: The<br>r designee should review and<br>n for residents with limitation<br>ensure the appropriate<br>ided to maintain and/or<br>motion. |                           |  |                         |
|                          | TIME PERIOD FO<br>(14) days.  | R CORRECTION: Fourteen   |                           |  |                         |
| 2 920                    | MN Rule 4658.052  | 5 Subp. 6 B Rehab - ADLs   | 2 920                     |  | 3/15/16                 |
|                          | comprehensive res<br>home must ensure<br>B. a resident who<br>activities of daily liv | b is unable to carry out<br>ving receives the necessary<br>n good nutrition, grooming,   |                           |  |                         |
|                          | by:<br>Based on observat  | ent is not met as evidenced<br>ion, interview and document<br>failed to provide appropriate  |                           | The preparation of the following plan of correction of this deficiency does not  |                         |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | LE CONSTRUCTION   | (X3) DATE<br>COMPI   |                        |
|--------------------------|---|--|-------------------------|---|--|------------------------|
|                          |   | 00803  | B. WING                 |   | 02/0   | 4/2016                 |
| NOODBI                   |   | CENTER 7012 LA<br>WOODE  | AKE ROAD<br>BURY, MN 55 |   |  |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY)  | N SHOULD BE<br>E APPROPRIATE   | (X5)<br>COMPLE<br>DATE |
| 2 920                    | Continued From pa   | age 9  | 2 920                   |   |  |                        |
|                          | grooming to 1 of 3<br>on staff for comple<br>(ADL.)<br>Findings include:<br>On 2/1/16, at 5:45<br>inch long hairs wer<br>and corners of the<br>still present on 2/2/<br>8:26 a.m.; and on 2<br>On 2/4/16, at 8:59<br>stated R105 had a<br>but NA-Z had not g<br>NA-Z stated R105<br>assignment list for<br>attempted to remove<br>dates. NA-Z stated<br>shaved but would t<br>today if the residen<br>the presence of the<br>On 2/3/16, at 3:40<br>not being able to p<br>whether or not the<br>On 2/3/16, at 3:47<br>R105's conservato<br>would bother R105<br>was unable to be in<br>The facility's policy<br>Program, dated 4/1<br>maintenance progr | residents (R105) dependent<br>tion of activities of daily living<br>p.m. approximately 1/8-1/4th<br>e noted on the resident's chin<br>mouth. The facial hairs were<br>'16, at 8:26 a.m.; on 2/3/16, at<br>2/4/16, at 8:34 a.m.<br>a.m. nursing assistant (NA)-Z<br>bath on Saturday evenings,<br>jiven R105 a bath that evening<br>had been on NA-Z's<br>2/3 and 2/4/16, and had not<br>ve R105's chin hairs on these<br>R105 would "fight" when<br>ry to remove the chin hairs<br>it would allow it. NA-Z verified<br>e chin hairs at this time.<br>p.m. a family member stated<br>rovide information as to<br>facial hair would bother R105<br>p.m. a message was left for<br>r to determine if the facial hair<br>, however, the conservator<br>nterviewed.<br>titled Functional Maintenance<br>15, indicated functional<br>ams were to be initiated to<br>a resident's highest practicable |                         | constitute and should not be<br>an admission nor an agree<br>facility of the truth of the fac<br>conclusions set forth in the<br>deficiencies. The plan of co-<br>prepared for this deficiency<br>solely because it is require<br>of State of Law. Without we<br>forgoing statement, the fac<br>1. With respect to R105, th<br>Manager is working with th<br>develop a routine for shaving<br>re-approaching or obtaining<br>of the nurse when resident<br>resident care plan and nur<br>assignment sheet have be<br>accordingly.<br>2. All residents have been<br>refusal of shaving and a pl<br>established for approaches<br>routine for shaving that best<br>residents needs. The NAR<br>sheet and resident care plat<br>revised as indicated.<br>3. All nursing staff will rece<br>by March 15, 2016 regardi<br>challenges during grooming<br>interventions/approaches to<br>individuals needs are met.<br>4. The Director of Nursing<br>designee will complete 5 re<br>each week for one month<br>audits each week for two re<br>assure care of the individu<br>being completed according<br>to the base for two re | ement by the<br>cts alleged on<br>e statement of<br>orrection<br>y was executed<br>d by provisions<br>aiving the<br>cility states that:<br>The Nurse<br>he staff to<br>ng the resident,<br>g the assistance<br>the sing assistant<br>en updated<br>reviewed for<br>an of care<br>is to promote a<br>st meets the<br>assignment<br>an have been<br>eive education<br>ng managing<br>g and<br>o ensure each<br>and/or<br>esident audits<br>and 3 resident is |                        |
|                          |   | THOD OF CORRECTION: Th<br>or designee should review  | e                       | individual plan of care.<br>5. The data collected will b<br>QAPI by the Director of Nu<br>will be reviewed/discussed  | irsing. The data   |                        |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A. BUILDING            | LE CONSTRUCTION   |  | SURVEY<br>LETED         |
|--------------------------|---|---|------------------------|---|--|-------------------------|
|                          |   | 00803   | B. WING                |   | 02/0   | 4/2016                  |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET #  | ADDRESS, CITY,         | STATE, ZIP CODE   |  |                         |
| NOODB                    | URY HEALTH CARE (   | SENTER  | KE ROAD<br>BURY, MN 55 | 125   |  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>(MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | ILD BE   | (X5)<br>COMPLET<br>DATE |
| 2 920                    | Continued From pa   | ige 10  | 2 920                  |   |  |                         |
|                          | an accurate reflecti<br>the resident. Nursir<br>on ensuring care w<br>accordance with ea<br>of care plans and o<br>conducted to ensur<br>to the care plan.  | to ensure the care plans wer<br>on of the services required by<br>ng staff could then be educate<br>as provided to residents in<br>the resident's care plan. Audit<br>bservation of cares could be<br>re care was provided accordin<br>R CORRECTION: Fourteen   | ,<br>id<br>s           | decision/recommendations made<br>regarding any necessary follow u   |  |                         |
| 21325                    | (14) days.  | 5 Subp. 1 Providing Routine 8   | k 21325                |   |  | 3/15/16                 |
|                          | Subpart 1. Routine<br>home must provide<br>resource, routine de<br>needs of each resid<br>include dental exan<br>fillings and crowns,<br>oral surgery, bridge<br>orthodontic procede<br>that are provided for | e dental services. A nursing<br>e, or obtain from an outside<br>ental services to meet the<br>dent. Routine dental services<br>ninations and cleanings,<br>root canals, periodontal care<br>is and removable dentures,<br>ures, and adjunctive services<br>or similar dental patients in the<br>, as limited by third party | ,                      |   |  |                         |
|                          | by:<br>Based on observati<br>review, the facility f<br>services were provi<br>on an annual basis<br>dental issues.<br>Findings include:<br>On 2/2/16, at 9:33 a   | ent is not met as evidenced<br>ion, interview and document<br>ailed to ensure routine dental<br>ided to 1 of 3 residents (R105<br>to ensure there were no<br>a.m. R105 was observed to<br>front teeth missing. On 2/3/16  | )                      | The preparation of the following p<br>correction of this deficiency does<br>constitute and should not be inter<br>an admission nor an agreement l<br>facility of the truth of the facts alle<br>conclusions set forth in the stater<br>deficiencies. The plan of correction<br>prepared for this deficiency was a<br>solely because it is required by p<br>of State of Law. Without waiving | not<br>rpreted as<br>by the<br>eged on<br>ment of<br>on<br>executed<br>rovisions |                         |

| STATEMEN                 | Dta Department of Hendric Department of Hend | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION   | (X3) DATE<br>COMPI  |                         |
|--------------------------|--|--|---------------------|---|---|-------------------------|
|                          |  | 00803  | B. WING             |   | 02/0  | 4/2016                  |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY,        | STATE, ZIP CODE   |   |                         |
| NOODB                    | URY HEALTH CARE  | CENTER 7012 LAK<br>WOODBU  | E ROAD<br>RY, MN 55 | 125   |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY)   | ULD BE  | (X5)<br>COMPLET<br>DATE |
| 21325                    | Continued From pa  | age 11   | 21325               |   |   |                         |
|                          | at 8:39 a.m. R105 y<br>size pieces of an o<br>no problems noted<br>The care plan revis<br>was to be referred<br>resident would grin<br>assess/observe for<br>Another portion of f<br>9/21/15, noted R10<br>missing, staff perfor<br>not participate, but<br>dentist as needed.<br>indicate R105 was<br>annual oral exams.<br>A dental agreemen<br>dental service reve<br>signed the form on<br>consulting dental s<br>comprehensive and<br>There was no indic<br>conservator did not<br>dentist.<br>A review of the com<br>record did not indic<br>since the dental ag<br>10/11/12.<br>On 2/3/16, at 3:22<br>stated they would of<br>record for any door<br>visits. By 2/4/16, at<br>able to find any door<br>On 2/4/16, at 11:30<br>(HUC)-A stated the<br>screening of R105   | was observed to feed self bite<br>melet and toast. There were<br>with chewing or swallowing.<br>Sed on 1/17/14, indicated R105<br>to the dentist as needed; the<br>d their teeth; and staff were to<br>r mouth and tooth issues.<br>the care plan revised on<br>05 had some natural teeth<br>ormed oral care, as R105 did<br>was cooperative; and refer to<br>However, the care plan did not<br>not to see the dentist for<br>t with the facility's contract<br>aled the conservator had<br>10/11/12, which authorized the |                     | forgoing statement, the facility s<br>1. With respect to R105, an oral<br>was completed and dental<br>recommendations presented to<br>for making determination for tre<br>2. All resident records have beed<br>by Health Information to ensured<br>been offered dental care/serviced<br>the past 12 months.<br>3. All Health Information staff wire-educated by March 15, 2016<br>the guidelines and process for cand other ancillary services.<br>4. The Director of Nursing and/c<br>designee will complete 2 reside<br>audits each week for one month<br>one resident chart audit each w<br>months to assure dental services<br>offered and obtained as request<br>5. The data collected will be pre<br>QAPI by the Director of Nursing<br>will be reviewed/recommendation<br>regarding any necessary follow | screen<br>the family<br>atment.<br>n audited<br>they have<br>es within<br>II be<br>regarding<br>lental visits<br>or<br>nt chart<br>and then<br>eek for two<br>is are<br>red.<br>sented at<br>. The data<br>ons made |                         |

STATE FORM

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                | E SURVEY<br>PLETED      |
|--------------------------|---|---|-------------------------|--|----------------|-------------------------|
|                          |   | 00803   | B. WING                 |  | 02/            | 04/2016                 |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST        | ATE, ZIP CODE  |                |                         |
| VOODBI                   | JRY HEALTH CARE (   | CENTER  | KE ROAD<br>URY, MN 5512 | 5  |                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 21325                    | Continued From pa   | age 12  | 21325                   |  |                |                         |
|                          | contracting dental s<br>screenings, but pro<br>the facility. HUC-A<br>dental issues that t<br>On 2/4/16, at 8:59 a<br>stated R105 was re    | reening. HUC-A stated the<br>service did not keep dental<br>wided the documentation to<br>stated R105 had not had any<br>hey were aware of.<br>a.m. nursing assistant (NA)-Z<br>esistive with oral cares, but<br>problems with chewing or       |                         |  |                |                         |
|                          | indicated annual de   | I Services policy, revised 8/13,<br>ental services and dental<br>ed were to be provided to  |                         |  |                |                         |
|                          | director of nurses of<br>resident's legal rep<br>annual dental servi<br>dental services wer<br>contacting the legal<br>staff should be made | THOD OF CORRECTION: The<br>resentative to determine if the<br>ces were to be provided or if<br>re only to be provided after<br>I representative. The nursing<br>de aware of all resident's<br>low to ensure dental services<br>in annual basis. |                         |  |                |                         |
|                          | TIME PERIOD FOI<br>(14) days.   | R CORRECTION: Fourteen  |                         |  |                |                         |
| 21375                    | MN Rule 4658.080<br>Program   | 0 Subp. 1 Infection Control;  | 21375                   |  |                | 3/15/16                 |
|                          | home must establis  | on control program. A nursing<br>sh and maintain an infection<br>signed to provide a safe and<br>nt.  |                         |  |                |                         |
|                          | epartment of Health   |   |                         |  |                |                         |

| PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>OSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)<br>reparation of the following plan of<br>ction of this<br>ency does not constitute and should<br>e interpreted as an admission nor an<br>ment by the facility of the truth of the  |
|---|
| PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>OSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)<br>reparation of the following plan of<br>ction of this<br>ency does not constitute and should<br>e interpreted as an admission nor an  |
| EACH CORRECTIVE ACTION SHOULD BE<br>OSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)<br>reparation of the following plan of<br>ction of this<br>ency does not constitute and should<br>e interpreted as an admission nor an   |
| EACH CORRECTIVE ACTION SHOULD BE<br>OSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)<br>reparation of the following plan of<br>ction of this<br>ency does not constitute and should<br>e interpreted as an admission nor an   |
| ction of this<br>ency does not constitute and should<br>e interpreted as an admission nor an  |
| ction of this<br>ency does not constitute and should<br>e interpreted as an admission nor an  |
| alleged on conclusions set forth in<br>atement of deficiencies. The plan of<br>ction prepared for this deficiency was<br>ited solely because it is required by<br>sions of State of Law. Without<br>ng the forgoing statement, the facility<br>that:<br>If immediately sanitized the<br>anical standing device and residents<br>s.<br>th respect to identified employee,<br>ation was provided to ensure proper<br>washing and cleaning of equipment<br>rovided between resident cares on<br>eary 3, 2016.<br>staff will be re educated regarding<br>washing and disinfecting resident<br>ment between resident use by March<br>016<br>e Director of Nursing and/or<br>nee will audit 5 resident cares each<br>for one month and 3 resident cares<br>week for 2 months to assure proper<br>washing and disinfection of<br>ment is occurring.<br>e data collected will be presented in<br>by the Director of Nursing. The data<br>e reviewed/discussed and<br>on/recommendations made<br>ding any necessary follow up studies. |
|   |

| -                        | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |  |                                   | E SURVEY<br>PLETED      |
|--------------------------|---|--|---------------------|--|-----------------------------------|-------------------------|
|                          |   | 00803  |                     |  | 02/                               | 04/2016                 |
| NAME OF F                | PROVIDER OR SUPPLIER  |  | T ADDRESS, CITY, S  |  | 02/                               | 04/2010                 |
| NOODB                    | URY HEALTH CARE   | CENTER   | AKE ROAD            | 25   |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21375                    | Continued From pa   | age 14   | 21375               |  |                                   |                         |
|                          | floor manager, (RN<br>perform hand hygie<br>with using the toile<br>the mechanical sta<br>storage as someor<br>away.<br>The Hand Washing<br>directed staff "Han<br>and effective steps<br>Dry) to reduce the<br>respiratory illness.<br>particularly before<br>one of the best way<br>getting sick, and pr<br>others." The policy<br>sanitizer may be us<br>soiled. | 6 a.m. the registered nurse<br>J)-B, reported staff should<br>ene after assisting a resident<br>t and should clean and sanit<br>and prior to returning it to<br>ne might need to use it right<br>g Policy, last revised 8/2013,<br>dwashing involves five simple<br>(Wet, Lather, Scrub, Rinse,<br>spread of diarrheal and<br>Regular handwashing,<br>and after certain activities, is<br>ys to remove germs, avoid<br>revent the spread of germs to<br>also directed staff that hand<br>sed if hands were not visibly | e<br>o              |  |                                   |                         |
|                          | directed staff "21. \   | ft Policy, last revised 12/2013<br>Wipe handles of the<br>a germicidal cloth." after us  |                     |  |                                   |                         |
|                          | The director of nur<br>and revise the polic<br>infection control co<br>medications, perfo<br>cares and provide<br>monitoring system<br>staff are providing  | THOD OF CORRECTION:<br>sing or designee would revie<br>cy and procedures related to<br>incerns while passing<br>rming wound care, perinal<br>education to staff members.<br>could be developed to ensu-<br>cares as directed and report<br>uality assurance committee.   | A<br>re             |  |                                   |                         |
|                          | TIME PERIOD FO<br>(21) days.  | R CORRECTION: Twenty-o   | ne                  |  |                                   |                         |

|   |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |  | LE CONSTRUCTION  |   | SURVEY<br>LETED         |
|---|---|---|--|--|---|-------------------------|
|   |   | 00803   | B. WING                                |  | 02/0  | 4/2016                  |
| IAME OF PR                                | OVIDER OR SUPPLIER  | STREE   | T ADDRESS, CITY,                       | STATE, ZIP CODE  |   |                         |
| VOODBUI                                   | RY HEALTH CARE (  | PENTER  | LAKE ROAD<br>DBURY, MN 55 <sup>.</sup> | 125  |   |                         |
| (X4) ID<br>PREFIX<br>TAG                  | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)  | SHOULD BE   | (X5)<br>COMPLET<br>DATE |
| 21426 (                                   | Continued From pa   | ge 15   | 21426                                  |  |   |                         |
|   | MN St. Statute 144<br>Prevention And Co   | A.04 Subd. 3 Tuberculosis ntrol   | 21426                                  |  |   | 3/15/16                 |
| i<br>i<br>r<br>i<br>r<br>r<br>i<br>c<br>r | current tuberculosis<br>ssued by the Unite<br>Control and Preven<br>Fuberculosis Elimir<br>Morbidity and Morta<br>Fhis program must<br>infection control pla<br>unpaid employees,<br>esidents, and volu<br>lealth shall provide<br>egarding implement | bgram according to the most<br>infection control guidelines<br>d States Centers for Diseas<br>tion (CDC), Division of<br>nation, as published in CDC<br>ality Weekly Report (MMWF<br>include a tuberculosis<br>in that covers all paid and<br>contractors, students,<br>inteers. The Department of<br>the technical assistance<br>intation of the guidelines. | s<br>se<br>'s<br>R).                   |  |   |                         |
| k<br>E<br>f<br>i<br>ŗ                     | by:<br>Based on documer<br>acility failed to doc<br>nduration results o   | ent is not met as evidenced<br>at review and interview, the<br>ument the interpretation and<br>f tuberculin skin test (TST)<br>5, R87, R148, R249 & R294  | d<br>for                               | The preparation of the follow<br>correction of this<br>deficiency does not constitute<br>not be interpreted as an adm<br>agreement by the facility of the<br>facts alleged on conclusions<br>the statement of deficiencies | e and should<br>lission nor an<br>he truth of the<br>set forth in |                         |
| F   | R5 was admitted to<br>nedical record indi<br>lose step of Tubers  | the facility on 5/22/15. R5's<br>cated R5 received the first<br>sol Solution 5 unit/0.1 millilit<br>on 5/22/15. There were no   |  | correction prepared for this c<br>executed solely because it is<br>provisions of State of Law. W<br>waiving the forgoing stateme<br>states that:   | leficiency was<br>required by<br>/ithout                          |                         |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIP<br>A. BUILDING | LE CONSTRUCTION   | (X3) DATE S<br>COMPL  |                         |
|--------------------------|---|---|----------------------------|---|---|-------------------------|
|                          |   | 00803   | B. WING                    |   | 02/04   | 4/2016                  |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY,              | STATE, ZIP CODE   |   |                         |
| VOODB                    | URY HEALTH CARE (   | CENTER  | KE ROAD<br>URY, MN 55      | 125   |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC   | ION SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLET<br>DATE |
| 21426                    | Continued From pa   | age 16  | 21426                      |   |   |                         |
|                          | induration of the TS<br>Furthermore, a sec<br>Solution 5 unit/0.1 m<br>given on 6/3/15, and<br>indicate the interpre-<br>given on 6/3/15.<br>R87 was admitted for<br>medical record indi-<br>dose step of Tuber<br>(ML) intradermally<br>documents to indic-<br>induration of the TS<br>Furthermore, a sec<br>Solution 5 unit/0.1 m<br>given on 10/10/15,<br>to indicate the inter<br>TST given on 10/10/<br>R148 was admitted<br>R148's medical record<br>the first dose step of<br>milliliter (ML) intrad<br>were no documents<br>or induration of the<br>R249 was admitted<br>R249's medical record<br>the first dose step of<br>milliliter (ML) intrad<br>were no documents<br>or induration of the<br>R294's medical record<br>the first dose step of<br>milliliter (ML) intrad<br>were no documents<br>or induration of the<br>R294's medical record<br>the first dose step of<br>milliliter (ML) intrad<br>were no documents<br>or induration of the | ate the interpretation or<br>ST given on 5/22/15.<br>cond dose step of Tubersol<br>milliliter (ML) intradermally was<br>ad there was no documents to<br>etation or induration of the TST<br>to the facility on 9/30/15. R87's<br>icated R87 received the first<br>rsol Solution 5 unit/0.1 milliliter<br>on 9/30/15. There were no<br>eate the interpretation or<br>ST given on 9/30/15.<br>cond dose step of Tubersol<br>milliliter (ML) intradermally was<br>and there was no documents<br>rpretation or induration of the<br>0/15.<br>d to the facility on 10/18/15.<br>cord indicated R148 received<br>of Tubersol Solution 5 unit/0.1<br>dermally on 10/18/15. There<br>s to indicate the interpretation<br>e TST given on 10/18/15.<br>d to the facility on 10/12/15.<br>cord indicated R249 received<br>of Tubersol Solution 5 unit/0.1<br>dermally on 10/12/15. There<br>s to indicate the interpretation<br>e TST given on 10/12/15.<br>d to the facility on 11/2/15.<br>cord indicated R249 received<br>of Tubersol Solution 5 unit/0.1<br>dermally on 10/12/15. There<br>s to indicate the interpretation<br>e TST given on 10/12/15.<br>d to the facility on 11/2/15.<br>d to the facility on 11/2/15. |                            | <ol> <li>With respect to the ide<br/>screens and 2 step manta<br/>initiated for residents R5,<br/>R249, and R 294.</li> <li>All new admissions for<br/>month have been reviewe<br/>proper screening, TST ac<br/>interpretation of results has<br/>a All licensed staff has re-<br/>regarding procedure for T<br/>including symptoms, risk<br/>interpretation of results. E<br/>completed by March 15, 2<br/>4. The Director of Nursing<br/>designee will audit 2 new<br/>residents each week for of<br/>then 1 newly admitted res-<br/>months to assure proper<br/>of the TB screening progroccurred.</li> <li>The data collected will<br/>the QAPI meeting by the<br/>Nursing. The data will be<br/>reviewed/discussed and<br/>decision/recommendatior<br/>regarding any follow up starts</li> </ol> | bux process was<br>R87, R148,<br>the current<br>ed to assure<br>dministration and<br>ad occurred.<br>eceived education<br>B screening<br>factors, testing,<br>Education will be<br>2016.<br>g and/or<br>ly admitted<br>one month and<br>sident for 2<br>implementation<br>ram has<br>be presented in<br>Director of |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         |  | E SURVEY<br>PLETED      |  |
|--------------------------|---|---|-------------------------|--|-------------------------|--|
|                          |   | 00803   | B. WING                 | 02/  | 02/04/2016              |  |
| IAME OF F                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, S         | STATE, ZIP CODE  |                         |  |
| VOODBI                   | JRY HEALTH CARE   | CENTER  | KE ROAD<br>SURY, MN 551 | 25   |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLET<br>DATE |  |
| 21426                    | Continued From pa   | age 17  | 21426                   |  |                         |  |
|                          | registered nurse (F<br>R249 & R294 did m<br>interpretation or inc<br>A review of the fact<br>Screening, read, "T<br>residents should in<br>day, year). the num<br>(if no induration, do<br>interpretation (i.e.,<br>SUGGESTED MET<br>DON or designee of<br>screening audits, in | on 2/4/15, at 11:00 a.m.<br>RN)-E verified (R5, R87, R148<br>ot have documented<br>duration of the TST.<br>lity policy dated 2013, titled<br>"ST documentation for<br>clude the date (i.e., month,<br>ber of millimeters of induratio<br>ocument "0" mm), and<br>positive or negative)."<br>THOD OF CORRECTION: The<br>could conduct resident | n                       |  |                         |  |
|                          | disease. The DON<br>staff were educated<br>induration and inter<br>testing. The DON of<br>audit resident's doo<br>documentation for   | re free from communicable<br>or designee could ensure the<br>d on the importance of<br>rpretation of tuberculin skin<br>or designee could randomly<br>cuments to ensure adequate<br>induration and interpretation.<br>R CORRECTION: Fourteen  |                         |  |                         |  |
|                          | (14) days.  |   |                         |  |                         |  |
| 21620                    | MN Rule 4658.134  | 5 Labeling of Drugs   | 21620                   |  | 3/15/16                 |  |
|                          | Drugs used in the in accordance with  | nursing home must be labeled<br>part 6800.6300.   |                         |  |                         |  |
|                          | by:<br>Based on observat<br>review, the facility f<br>were stored and la  | ent is not met as evidenced<br>ion, interview and document<br>ailed to ensure medications<br>beled properly for 3 of 45<br>123 and R234) reviewed for   |                         | The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the | 3                       |  |

STATE FORM

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                       | PLE CONSTRUCTION  | (X3) DATE S<br>COMPL   |                         |
|--------------------------|---|--|-----------------------|---|--|-------------------------|
|                          |   | 00803  | B. WING               |   | 02/04/2016   |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY,         | STATE, ZIP CODE   |  |                         |
| NOODB                    | URY HEALTH CARE (   | CENTER   | KE ROAD<br>URY, MN 55 | 125   |  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)  | HOULD BE   | (X5)<br>COMPLET<br>DATE |
| 21620                    | Continued From pa   | age 18   | 21620                 |   |  |                         |
|                          | medication storage  | ·.   |                       | facility of the truth of the facts  |  |                         |
|                          | storage areas throu   | s of multiple medication<br>ughout the facility, medications   |                       | conclusions set forth in the st<br>deficiencies. The plan of corr<br>prepared for this deficiency w<br>solely because it is required b<br>of State of Law. Without waiv   | ection<br>vas executed<br>by provisions<br>ing the                           |                         |
|                          | drops, ear drop and<br>indicate when they   | ·  |                       | forgoing statement, the facilit<br>1. With respect to residents F<br>R332; medications were rem<br>storage areas and disposed of<br>2. All mediantian storage area  | R123,R234,<br>oved from the<br>of properly.                                  |                         |
|                          | 9:10 a.m. with regis<br>transition care unit<br>multiple opened, us                     | ion storage tour on 2/3/16, at<br>stered nurse (RN)-A, in the<br>team 3 medication cart,<br>sed and undated medication<br>in medication carts.<br>ded the following: |                       | 2. All medication storage area<br>inspected for proper compliar<br>handling, storage and dating<br>medications. All medications<br>compliance have been dispos<br>according to facility protocol.   | nce with<br>of opened<br>not in  |                         |
|                          | bottle was opened,<br>R332's Ciprodex (fe<br>was opened, used                           | diabetes) insulin vial was   |                       | 3. Processes have been dever<br>periodic inspection of the merestorage areas for cleanliness<br>storage and disposal. All licer<br>staff/trained medication aides<br>educated regarding medication<br>and storage guidelines by Ma                        | dication<br>, proper<br>nsed<br>s will be re<br>on expiration                |                         |
|                          | medications neede<br>properly. RN-A add<br>should be dated wh                           | a.m. RN-A verified the<br>d to be labeled and stored<br>led that opened medications<br>nen opened and stated she will<br>lication cart, disposed properly            |                       | <ol> <li>The Director of Nursing an<br/>designee will audit 3 medicati<br/>areas each week for one mor<br/>medication storage areas eac<br/>months to assure proper stor<br/>and disposal of expired medic<br/>5. The data collected will be p</li> </ol> | d/or<br>ion storage<br>hth and 2<br>ch week for 2<br>age, dating<br>cations. |                         |
|                          | 9:41 a.m., with LPN<br>medication storage<br>following observation<br>R234's Latanopros | ion administration on 2/3/16, a<br>J-A, the third floor south<br>cart was reviewed. The<br>on was made:<br>t (anti-glaucoma) eye drop<br>used and was undated.       | t                     | QAPI by the Director of Nursi<br>will be reviewed/discussed ar<br>decision/recommendations m<br>regarding any follow up studie  | ng. The data<br>nd<br>nade   |                         |
|                          | medications should  | a.m. LPN-A verified the<br>I be labeled and stored<br>ded that opened medications  |                       |   |  |                         |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                       | CONSTRUCTION   |                                   | E SURVEY<br>PLETED      |  |  |
|--------------------------|---|---|---------------------------|--|-----------------------------------|-------------------------|--|--|
|                          |   | 00803   | B. WING                   | B. WING  |                                   | 02/04/2016              |  |  |
| IAME OF I                | PROVIDER OR SUPPLIER  | STREET  | ADDRESS, CITY, ST         | DDRESS, CITY, STATE, ZIP CODE  |                                   |                         |  |  |
| VOODB                    | URY HEALTH CARE   | CENTER  | AKE ROAD<br>BURY, MN 5512 | 5  |                                   |                         |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |  |
| 21620                    | Continued From pa   | age 19  | 21620                     |  |                                   |                         |  |  |
|                          | should be dated wh<br>and reorder new or  | nen opened and will removed<br>nes.   | k                         |  |                                   |                         |  |  |
|                          | (DON) explained the medication bottles addition, the DON  | a.m. the director of nursing<br>nat staff were supposed to da<br>and vials when opened. In<br>indicated that staff should<br>pharmacy recommendations   |                           |  |                                   |                         |  |  |
|                          | guidelines, directed<br>opened - room tem<br>use, date when op  | n storage and expiration<br>d, "insulin 10 ML (milliliter) via<br>operature, 28 days after 1st<br>en yes. Xalatan eye drops<br>operature, 45 days after 1st<br>en yes."   | als                       |  |                                   |                         |  |  |
|                          | BEYOND-USE DA<br>"D. Certain medica<br>specified by the ma<br>on storage condition<br>(see chart for examination)   | TING, dated 1/27/15, reads,<br>tions have beyond-use dates<br>anufacturer that are depende<br>ons and/or date of this use.<br>nple). Nursing staff will write<br>the container label for these<br>ons."   | ent                       |  |                                   |                         |  |  |
|                          | administrator, direc<br>consulting pharma<br>policies and proced<br>medications. Nursi<br>necessary to the in<br>medications proper<br>medications. The D | THOD OF CORRECTION: T<br>ctor of nursing (DON) and<br>cist could review and revise<br>dures for proper storage of<br>ng staff could be educated a<br>nportance of labeling<br>rly and discarding expired<br>DON or designee, along with<br>uld audit medications on a<br>sure compliance. | s                         |  |                                   |                         |  |  |
|                          | TIME PERIOD FO<br>(21) days.  | R CORRECTION: Twenty on   | ie                        |  |                                   |                         |  |  |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                       |  | ATE SURVEY                                 |  |
|--------------------------|---|---|-----------------------|--|--|--|
|                          |   | 00803   | B. WING               | 0  | 02/04/2016                                 |  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY,          | STATE, ZIP CODE  |  |  |
| NOODB                    | URY HEALTH CARE   | CENTER 7012 LAR<br>WOODBU   | KE ROAD<br>JRY, MN 55 | 125  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLET<br>DATE                    |  |
| 21685                    | Continued From pa   | age 20  | 21685                 |  |  |  |
| 21685                    | MN Rule 4658.141<br>Housekeeping, Op  | 5 Subp. 2 Plant<br>eration, & Maintenance   | 21685                 |  | 3/15/16                                    |  |
|                          | including walls, floo<br>systems, and equip<br>continuous state of<br>with regard to the h<br>well-being of the re<br>routine maintenance   | plant. The physical plant,<br>brs, ceilings, all furnishings,<br>oment must be kept in a<br>i good repair and operation<br>health, comfort, safety, and<br>esidents according to a written<br>be and repair program.<br>ent is not met as evidenced   |                       |  |  |  |
|                          | by:<br>Based on observat<br>failed to ensure cup<br>6 kitchenettes were<br>This had the poten<br>residents residing i<br>Findings include:<br>During the final kitc<br>a.m. to 10:25 a.m.<br>kitchenette cabinet<br>2 West units were<br>raw wood in some<br>In the 3 North dinin<br>of 5 drawers were<br>making the surface<br>The director of nut | ion, and interview, the facility<br>oboards and/or drawers in 4 of<br>e maintained in good repair.<br>tial to affect 100 of 165<br>n the facility.<br>chen tour on 2/4/16, from 9:35<br>the wood finishes of lower<br>s in the 3 North, 3 South, and<br>noted to be worn down to the<br>places.<br>og room the inside bottom of 3<br>worn down to the raw wood,<br>e uncleanable. |                       | The preparation of the following plan of<br>correction of this<br>deficiency does not constitute and should<br>not be interpreted as an admission nor a<br>agreement by the facility of the truth of th<br>facts alleged on conclusions set forth in<br>the statement of deficiencies. The plan of<br>correction prepared for this deficiency we<br>executed solely because it is required by<br>provisions of State of Law. Without<br>waiving the forgoing statement, the facilit<br>states that:<br>1. With respect to the identified kitchen<br>cabinets, all identified cabinets have been<br>cleaned and repaired.<br>2. Environmental Rounds have been<br>conducted to identify any items in need of<br>repair.<br>3. All staff will be re educated regarding | n<br>he<br>of<br>as<br>'<br>ty<br>en<br>of |  |
|                          | cupboards and see<br>and refinished.<br>The facility was una  | nce would look at the<br>about having them cleaned<br>able to provide a preventative<br>dule for the kitchenette  |                       | <ul> <li>reporting items in need of repair by Marce 15, 2016</li> <li>4. The Director of Maintenance and/or designee will complete audits weekly for months and then on a monthly basis to make needed repairs or schedule larger</li> </ul>   | 3  |  |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                                      | LE CONSTRUCTION   |  | SURVEY<br>LETED         |
|--------------------------|--|---|--------------------------------------|---|--|-------------------------|
|                          |  | 00803   | B. WING                              | B. WING   |  |                         |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET  | ADDRESS, CITY,                       | STATE, ZIP CODE   |  |                         |
| NOODB                    | URY HEALTH CARE  | CENTER  | AKE ROAD<br>BURY, MN 55 <sup>.</sup> | 125   |  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                  | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | N SHOULD BE  | (X5)<br>COMPLET<br>DATE |
| 21685                    | Continued From pa  | age 21  | 21685                                |   |  |                         |
|                          | administrator or de<br>kitchenette cabinet<br>refinished; and the<br>drawers were refini<br>surface. The admir<br>nursing, dietary, ma<br>housekeeping staff | f to conduct periodic audits of<br>ensure the cabinets were kep   | 1                                    | projects.<br>5. The data collected will be<br>QAPI by the Director of Mai<br>data will be reviewed/discus<br>decision/recommendations<br>regarding any necessary fo   | ntenance. The<br>ssed and<br>will be made                              |                         |
| 01005                    | days.  | R CORRECTION: Thirty (30)   |                                      |   |  | 0/45/40                 |
| 21695                    | Subp. 4. Housekeep<br>provide housekeep<br>necessary to maint<br>comfortable interio   | 5 Supp. 4 Plant<br>eration, & Maintenance<br>eeping. A nursing home must<br>bing and maintenance service<br>tain a clean, orderly, and<br>r, including walls, floors,<br>fixtures, equipment, lighting, |                                      |   |  | 3/15/16                 |
|                          | by:<br>Based on observat<br>failed to ensure cu<br>6 kitchenettes were   | ent is not met as evidenced<br>ion, and interview, the facility<br>pboards and/or drawers in 4 o<br>e kept clean. This had the<br>00 of 165 residents residing  | of                                   | The preparation of the follow<br>correction of this<br>deficiency does not constitu<br>not be interpreted as an adu<br>agreement by the facility of<br>facts alleged on conclusions<br>the statement of deficiencie | ite and should<br>mission nor an<br>the truth of the<br>s set forth in |                         |

STATE FORM

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If continuation sheet 22 of 29

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIEF<br>IDENTIFICATION NUM                                  |   | PLE CONSTRUCTION G:   | (X3) DATE<br>COMP  | SURVEY<br>LETED         |
|--------------------------|---|---|---|---|--|-------------------------|
|                          |   | 00803   | B. WING   |   | 02/0   | 4/2016                  |
| IAME OF I                | PROVIDER OR SUPPLIER  |   | STREET ADDRESS, CITY  | , STATE, ZIP CODE   |  |                         |
| VOODB                    | URY HEALTH CARE (   | renter  | 7012 LAKE ROAD<br>WOODBURY, MN 5  | 5125  |  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY F<br>SC IDENTIFYING INFORMAT | ULL PREFIX  | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC  | ION SHOULD BE  | (X5)<br>COMPLET<br>DATE |
| 21695                    | Continued From pa   | age 22  | 21695   |   |  |                         |
|                          | <ul> <li>During the final kitchen tour on 2/4/16, from 9:35 a.m. to 10:25 a.m. the lower cabinet doors of the 3 North and 2 West units had white spots/spills down the front of the doors.</li> <li>In the 1 West dining room the lower corners of 3 of 6 upper kitchenette cabinets were sticky to the touch and a debris was noted on the fingers after touching the cabinet corners. The director of nutritional services touched the corners of the cabinets, stated they were sticky and asked the housekeeper in the room to clean the cabinets.</li> <li>The director of nutritional services stated at 10:05 a.m. that it was housekeeping's responsibility to clean the outside of the kitchenette cabinets.</li> <li>The facility was unable to provide a preventative maintenance or cleaning schedule for the kitchenette cabinets.</li> <li>SUGGESTED METHOD OF CORRECTION: The administrator or designee, could ensure the kitchenette cabinets were cleaned. The administrator could coordinate with nursing,</li> </ul> |   | rs of the<br>s/spills<br>ers of 3<br>ky to the<br>ers after<br>or of<br>of the<br>ced the<br>poinets.<br>at 10:05<br>bility to<br>rets.<br>entative<br>entative<br>entative | <ul> <li>correction prepared for the executed solely because provisions of State of Law waiving the forgoing state states that:</li> <li>1. With respect to the ide cabinets, all identified ca cleaned and repaired.</li> <li>2. Environmental Rounds conducted to identify any repair.</li> <li>3. All staff will be re educe reporting items in need of 15, 2016</li> <li>4. The Director of Mainter designee will complete a months and then on a me make needed repairs or projects.</li> <li>5. The data collected will QAPI by the Director of Mainter decision/recommendatio regarding any necessary</li> </ul> | it is required by<br>w. Without<br>ement, the facility<br>entified kitchen<br>binets have been<br>items in need of<br>rated regarding<br>f repair by March<br>nance and/or<br>udits weekly for 3<br>onthly basis to<br>schedule larger<br>be presented at<br>Maintenance. The<br>cussed and<br>ns will be made |                         |
|                          | to conduct periodic<br>ensure the cabinets<br>TIME PERIOD FOR   | audits of the kitchene  | ittes to  |   |  |                         |
| 21710                    | days.<br>MN Rule 4658.141<br>Housekeeping, Op   | 5 Subp. 7 Plant<br>eration, & Maintenanc                                      | 21710<br>e  |   |  | 3/15/16                 |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | LE CONSTRUCTION  | (X3) DATE S<br>COMPL  |                        |
|--------------------------|---|---|---------------------|--|---|------------------------|
|                          |   | 00803   | B. WING             |  | 02/04/2016  |                        |
|                          | PROVIDER OR SUPPLIER  | STREET A  |                     | STATE, ZIP CODE  |   |                        |
|                          |   | 7012   4  | KE ROAD             |  |   |                        |
| NOODBI                   | JRY HEALTH CARE   | CENTER  | URY, MN 55          | 125  |   |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | ILD BE  | (X5)<br>COMPLE<br>DATE |
| 21710                    | Continued From pa   | age 23  | 21710               |  |   |                        |
|                          |   | -   |                     |  |   |                        |
|                          | supplied to sinks a maintained within a   | r temperature. Hot water<br>nd bathing fixtures must be<br>a temperature range of 105<br>it to115 degrees Fahrenheit at                               |                     |  |   |                        |
|                          | by:<br>Based on observat<br>review, the facility<br>temperatures withi  | ent is not met as evidenced<br>ion, interview and document<br>failed to maintain water<br>n acceptable limits for 3 of 4<br>iewed, rooms 118, 236 and |                     | The preparation of the following p<br>correction of this<br>deficiency does not constitute and<br>not be interpreted as an admission<br>agreement by the facility of the true  | d should<br>on nor an<br>uth of the   |                        |
|                          | Findings include:   |   |                     | facts alleged on conclusions set f<br>the statement of deficiencies. The<br>correction prepared for this defici  | e plan of<br>ency was   |                        |
|                          | An environmental tour was completed on 2/3/16,<br>between 3:30 p.m. and 4:30 p.m. with the<br>maintenance supervisor (MS). The following<br>water temperatures were noted in resident<br>bathroom sinks, using the facility water<br>thermometer: room 118: 116.7 F [degrees<br>Fahrenheit]; room 236: 117.1 F and room 319:<br>116.6 F. MS confirmed findings. MS reported the<br>facility completed audits for hot water in resident<br>rooms and provided a log for surveyor. However,<br>MS reported the facility allowed an upper limit of<br>120 F. MS reported he would adjust the hot water<br>system so water would reach an upper limit of<br>115 F in resident rooms and bathrooms.<br>The Water Temperature Policy, last revised<br>3/12/15, directed staff: "The water temperatures<br>for all public areas, resident rooms (including tubs<br>and showers) will stay in a range of 105 degrees<br>to 115 degrees Fahrenheit." |   |                     | <ul> <li>executed solely because it is required provisions of State of Law. Witho waiving the forgoing statement, the states that:</li> <li>1. With respect to water temperate Director of Maintenance adjusted water system on February 3, 201 water temperatures would reach a limit of 115 degrees Fahrenheit.</li> <li>2. The water temperature controll replaced on the hot water tank or 3. All maintenance staff will receive education regarding the procedur monitoring and documenting water temperatures daily. Water temperatures daily. Water temperatures daily. Water temperatures daily are to be reported to Director of Maintenance immedia Education will be completed by M 2016</li> <li>4. The Director of Maintenance was a statement of the statement of th</li></ul> | ut<br>he facility<br>tures; the<br>l the hot<br>6 so the<br>an upper<br>ler was<br>h 2/11/16.<br>ve<br>re for<br>er<br>ratures<br>the<br>ttely.<br>farch 15,<br>vill and/or |                        |
|                          |   | THOD OF CORRECTION: supervisor, administrator or  |                     | designee will audit water tempera<br>weekly to assure temperatures be<br>recorded daily are maintained wit<br>range.   | eing  |                        |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                       | LE CONSTRUCTION  | (X3) DATE<br>COMF | SURVEY                  |
|--------------------------|---|--|-----------------------|--|-------------------|-------------------------|
|                          |   | 00803  | B. WING               |  | 02/0              | 04/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY,         | STATE, ZIP CODE  |                   |                         |
| WOODB                    | URY HEALTH CARE (   | CENTER   | KE ROAD<br>URY, MN 55 | 125  |                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)   | I SHOULD BE       | (X5)<br>COMPLET<br>DATE |
| 21710                    | Continued From pa   | age 24   | 21710                 |  |                   |                         |
|                          | procedures related<br>to sinks and bathin<br>a temperature rang<br>to115 degrees Fah<br>maintenance super<br>designee could dev<br>and develop a mon<br>water supplied to s<br>maintained within a<br>degrees Fahrenhei<br>the fixtures.  | iew and revise policies and<br>to ensuring hot water supplied<br>g fixtures is maintained within<br>ge of 105 degrees Fahrenheit<br>renheit at the fixtures.The<br>rvisor, administrator or<br>velop a system to educate staff<br>itoring system to ensure hot<br>inks and bathing fixtures is<br>a temperature range of 105<br>t to115 degrees Fahrenheit at<br>R CORRECTION: Twenty-one  |                       | 5. The data collected will be<br>the QAPI meeting by the Din<br>Maintenance. The data will<br>reviewed/discussed and<br>decision/recommendations<br>follow up studies. | rector of<br>be   |                         |
| 21825                    | Residents of HC Fa<br>Subd. 9. Informat<br>Residents shall be<br>complete and curre<br>their diagnosis, trea<br>prognosis as require<br>duty to disclose. Th<br>terms and languag<br>be expected to und<br>accompanied by a<br>chosen representa<br>shall include the lik<br>psychological resul<br>alternatives. In cas<br>inadvisable, as doo<br>physician in a resid<br>information shall be<br>guardian or other p<br>resident as a repre<br>right to refuse this i | tion about treatment.<br>given by their physicians<br>ent information concerning<br>atment, alternatives, risks, and<br>red by the physician's legal<br>his information shall be in<br>e the residents can reasonably<br>lerstand. Residents may be<br>family member or other<br>tive, or both. This information<br>ely medical or major<br>ts of the treatment and its<br>es where it is medically<br>sumented by the attending<br>lent's medical record, the<br>e given to the resident's<br>person designated by the<br>sentative. Individuals have the |                       |  |                   | 3/15/16                 |

|               | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION  | (X3) DATE S<br>COMPL  |                |
|---------------|---|--|---------------------|--|---|----------------|
|               |   | 00803  | B. WING             |  | 02/04/2016  |                |
| NAME OF F     | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY,        | STATE, ZIP CODE  |   |                |
| WOODB         | URY HEALTH CARE   | CENTER 7012 LAK<br>WOODBU  | E ROAD<br>RY, MN 55 | 125  |   |                |
| (X4) ID       | SUMMARY ST  | ATEMENT OF DEFICIENCIES  | ID                  | PROVIDER'S PLAN OF CORRECT   | ON  | (X5)           |
| PRÉFIX<br>TAG |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG       | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRC<br>DEFICIENCY)   | LD BE<br>PRIATE   | COMPLE<br>DATE |
| 21825         | Continued From pa   | age 25   | 21825               |  |   |                |
|               | the time of admiss<br>alternative effective<br>which the treating<br>including surgical,<br>chemotherapeutic  | I be fully informed, prior to or at<br>ion and during her stay, of all<br>e methods of treatment of<br>physician is knowledgeable,<br>radiological, or<br>treatments or combinations of<br>e risks associated with each of |                     |  |   |                |
|               | by:<br>Based on interview<br>facility failed to obt<br>R161's family decisi<br>initiation of occupa<br>resident reviewed<br>Findings include:<br>Review of R161's r | nent is not met as evidenced<br>v and document review, the<br>ain informed consent from<br>sion makers, (F)-A, prior to the<br>tional therapy for 1 of 1<br>for informed consent, (R161).                                  |                     | The preparation of the following p<br>correction of this deficiency does<br>constitute and should not be inter<br>an admission nor an agreement b<br>facility of the truth of the facts alle<br>conclusions set forth in the staten<br>deficiencies. The plan of correction<br>prepared for this deficiency was e<br>solely because it is required by pr<br>of State of Law. Without waiving t | not<br>preted as<br>by the<br>ged on<br>nent of<br>on<br>executed<br>ovisions |                |
|               | was significantly co<br>During interview or<br>reported he was a<br>health and financia<br>reported he receive<br>form which indicate                               | an 2/1/16, at 7:04 p.m., F-A<br>designated decision maker for<br>al matters for R161. F-A<br>ed an explanation of benefit<br>ed he owed over \$90 for<br>py (OT) for the month of  |                     | forgoing statement, the facility sta<br>1. With respect to resident #161,<br>resident decision maker has beer<br>informed of the Occupational The<br>services provided. Facility has off<br>refund costs incurred to the family<br>2. All residents currently receiving<br>therapies have been reviewed to   | ttes that:<br>the<br>rapy<br>ered to<br>/.<br>I rehab                         |                |
|               | November. F-A the<br>would get similar s<br>January. F-A repor<br>was receiving occu<br>told by the facility t<br>that it was ending a                              | en reported he found out he<br>tatements for December and<br>ted he was not aware R161<br>upational therapy until he was<br>o come down and sign a form<br>and received a form in the mail<br>d owe over \$90 for OT in    |                     | informed consents have been cor<br>with appropriate decision maker.<br>3. All licensed staff receiving phys<br>orders for rehab therapies will not<br>resident decision maker of new o<br>rationale. All licensed nursing stat<br>re-educated by March 15, 2016 re   | npleted<br>sician<br>ify<br>rders and<br>if will be                           |                |

| STATEME | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                       | LE CONSTRUCTION   | (X3) DATE<br>COMPI   |                |  |
|---------|---|---|-----------------------|---|--|----------------|--|
|         |   | 00803   | B. WING               |   | 02/0   | 02/04/2016     |  |
| AME OF  | PROVIDER OR SUPPLIER  | STREET AL   | DRESS, CITY,          | STATE, ZIP CODE   | • • • • •  |                |  |
| VOODB   | URY HEALTH CARE (   | ENTER   | KE ROAD<br>JRY, MN 55 | 125   |  |                |  |
| (X4) ID | SUMMARY STA   |   |                       | PROVIDER'S PLAN OF CORF   | ECTION   | (X5)           |  |
| PREFIX  |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG         | (EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY)  |  | COMPLE<br>DATE |  |
| 21825   | Continued From pa   | age 26  | 21825                 |   |  |                |  |
|         | November . F-A rep<br>getting new silverw<br>the extent of servic<br>it would be several<br>November, Decem<br>he would want to be<br>any rehabilitation se<br>had told the facility<br>occurred about a ye<br>needed rehabilitation<br>have it, but he wan<br>make that determin<br>On 2/3/16, at 12:48<br>rehabilitation therap<br>just informed after<br>or so ago that F-A I<br>not being fully infor<br>OT. DRT reported<br>improve self feedin<br>December and Jan<br>rehabilitation therap<br>informed consent for<br>services. DRT repor-<br>obtain informed con<br>resident decision m<br>rehabilitation therap<br>had recently discus<br>learning of F-A's co<br>documented. DRT<br>rehabilitation therap<br>had recently discus<br>learning informed co<br>services. There wa<br>ensure informed co<br>the start of rehabilit<br>to her knowledge, f<br>funds to pay the co<br>OT services, even<br>not obtained. A poli | borted he had heard R161 was<br>are from OT, but had no idea<br>es R161 was receiving or that<br>sessions of OT during<br>ber and January. F-A reported<br>e fully informed in advance of<br>ervices prior to initiation and<br>this after a similar incident<br>ear prior. F-A reported if R161<br>on therapy, he wanted her to<br>ted enough information to |                       | the process for notification when worders.<br>4. The Director of Nursing and designee will audit 3 therapy of each week for one month and referrals each week for two massure informed consent has received on new therapy order new orders for therapy service obtained.<br>5. The data collected will be p QAPI by the Director of Nursin will be reviewed/discussed and decision/recommendations maregarding any necessary follows and the service of the | d/or<br>referrals<br>I two therapy<br>onths to<br>been<br>rs as long as<br>es have been<br>resented at<br>ng. The data<br>d<br>ade |                |  |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                | E SURVEY<br>PLETED      |
|--------------------------|---|---|-------------------------|--|----------------|-------------------------|
|                          |   | 00803   | B. WING                 |  | 02/            | 04/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, S         | TATE, ZIP CODE   |                |                         |
| WOODB                    | URY HEALTH CARE (   | CENTER  | KE ROAD<br>URY, MN 5512 | 25   |                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 21825                    | Continued From pa   | age 27  | 21825                   |  |                |                         |
|                          | services was reque  | ested but not provided.   |                         |  |                |                         |
|                          | 2/4/16, revealed F-<br>maker for R161's fi<br>Another family mer<br>emergency contact<br>Review of R161's C<br>Progress and Upda<br>Therapist Progress<br>dated 11/10/15 to 1<br>received OT servic<br>ability between thos<br>Review of a Conce        | rn and/or Questions Form,   |                         |  |                |                         |
|                          | See attached thera<br>will be more for De<br>when therapy is pro<br>surprise! [F-A-phor<br>Explanation of Ben<br>claims for OT servi<br>11/23/15. R161 was  | a hand written note: "Therapy:<br>apy charge understand there<br>c and Jan-Please let me know<br>by by ded in the future. This is a<br>ne number]. Attached was an<br>efits, dated 1/9/16 with 10<br>ces between 11/10/15 and<br>s responsible for paying<br>ervices. A handwritten note<br>nonths later."  |                         |  |                |                         |
|                          | attachment with an<br>effective 11/10/15 u<br>noted "Treatment F<br>and alternatives dis<br>family, who agree t<br>note did not indicat<br>informed consent a<br>received. The note<br>informed consent fi<br>decision maker for<br>matters, (F)-A. The | ility sent an email and<br>OT care plan, dated 11/10/15,<br>until 12/7/15. The OT care plan<br>Plan, including benefits, risks<br>scussed with patient and/or<br>o treatment." However, the<br>e the individual that gave<br>and the date and time it was<br>e did not indicate OT obtained<br>rom R161's designated<br>healthcare and financial<br>e note did not indicate how F-A<br>e treatment plan, risks, |                         |  |                |                         |

| STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         00803         NAME OF PROVIDER OR SUPPLIER       STREET AI |  |  |                         |   | (X3) DATE SURVEY<br>COMPLETED<br>02/04/2016 |                        |
|--|--|--|-------------------------|---|---|------------------------|
|  |  | 00803  |                         |   |   |                        |
|  |  | DDRESS, CITY, STATE, ZIP CODE  |                         | 1   |   |                        |
| VOODB  | URY HEALTH CARE  | CENTER   | KE ROAD<br>URY, MN 5512 | 25  |   |                        |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE           | (X5)<br>COMPLE<br>DATE |
| 21825  | benefits and altern<br>benefits and altern<br>ensure it was in a r<br>There was no docu<br>given updates on u<br>12/8/15, 12/28/15 a<br>11/10/15 and endir<br>SUGGESTED ME<br>The administrator,<br>could review and/o<br>procedure regardir<br>education to staff p<br>policy and procedu<br>consent. The admi<br>designee would ini<br>compliance. | atives and what plan, risks,<br>atives were discussed to<br>manner F-A could understand.<br>umentation indicating F-A was<br>updated plans of care, dated<br>and 1/18/16 since initiation on |                         |   |   |                        |