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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XFC1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00829

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245320**

2.STATE VENDOR OR MEDICAID NO.
(L2) **679736900**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODLYN HEIGHTS HEALTHCARE CENTER**
(L4) **2060 UPPER 55TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements

Compliance Based On:

X 1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Mandatory DOPNA, effective 06/10/16, is rescinded effective 05/06/16.

17. SURVEYOR SIGNATURE — Date :
Mary Capes, HFE NE II — 05/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/27/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/12/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245320
May 27, 2016

Ms. Nicole Donahue, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

Dear Ms. Donahue:

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

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

Effective May 6, 2016 the above facility is certified for or recommended for:

99 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 99 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 24, 2016

Ms. Nicole Donahue, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

RE: Project Number S5320027, S5320026

Dear Ms. Donahue:

On March 25, the Minnesota Department of Health informed you the following enforcement remedy was being imposed:

- State Monitoring, effective April 19, 2016. (42 CFR 488.422

On April 6, 2016, CMS informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 10, 2016. (42 CFR 488.417 (b))

- Federal Civil Money Penalty of $8,050.00 per instance of noncompliance at F314 (S/S: G) identified in the CMS-2567 for the survey ending March 10, 2016

Also, CMS notified you in their letter of April 6, 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 March 10, 2016.

This was based on the deficiencies cited by this Department for a Minimum Data Set (MDS) 3.0/Staffing Focused Survey completed on March 10, 2016. The most serious health deficiencies in your facility at the time of the Minimum Data Set (MDS) 3.0/Staffing Focused Survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

In addition, a recertification survey was completed March 31, 2016. The most serious health deficiencies in your facility at the time of the standard survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 10, 2016, the Minnesota Department of Health and 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 Minimum Data Set (MDS) 3.0/Staffing Focused Survey, completed on March 10, 2016 and a standard survey completed March 31, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 6, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our Minimum Data Set (MDS) 3.0/Staffing Focused Survey, completed on March 10, 2016, and our recertification survey, completed March 31, 2016, as of May 6, 2016.

As a result of the PCR findings, this Department is discontinuing State Monitoring as of 5/10/2016.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of April 6, 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 June 10, 2016, be rescinded. (42 CFR 488.417 (b))

- Federal Civil Money Penalty of $8,050.00 per instance of noncompliance at F314 (S/S: G) identified in the CMS-2567 for the survey ending March 10, 2016, remain in effect.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective June 10, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 10, 2016, is to be rescinded.

In CMS' letter of April 6, 2016, you were advised that, in accordance with Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has been assessed a total civil money penalty of not less than $5,000.00. Therefore, Woodlyn Heights Healthcare Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective March 8, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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 PCR with the President of your facility's Governing Body.

Enclosed are copies of the Post Certification Revisit Forms, (CMS-2567B) from this visit.

Feel free to contact me if you have 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
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245320 Y1	A. Building B. Wing Y2	5/10/2016 Y3

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

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0314	Correction	ID Prefix F0329	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(l)	Completed
LSC	04/19/2016	LSC	04/19/2016	LSC	04/19/2016
ID Prefix F0428	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/19/2016	LSC		LSC	
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 05/24/2016	SIGNATURE OF SURVEYOR 22580	DATE 05/10/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/10/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245320	A. Building 01 - MAIN BUILDING 01 B. Wing	4/28/2016

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

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 04/24/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 04/24/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 05/24/2016	SIGNATURE OF SURVEYOR 37010	DATE 04/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/30/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245320 (Y1)	A. Building 02 - 2014 ADDITION B. Wing (Y2)	4/28/2016 (Y3)

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

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 04/24/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 04/24/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 05/24/2016	SIGNATURE OF SURVEYOR 37010	DATE 04/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/30/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Y6XW11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00829

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245320**

2.STATE VENDOR OR MEDICAID NO.
(L2) **679736900**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODLYN HEIGHTS HEALTHCARE CENTER**
(L4) **2060 UPPER 55TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

4. TYPE OF ACTION: **9** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 03/10/2016 (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)

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

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Momodou Fatty, HFE NE II — 04/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/06/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN: 24-5320

On March 10, 2016, a Minimum Data Set (MDS) 3.0/Staffing Focused Survey was completed to verify compliance with Federal certification regulations. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

Post Certification Revisit (PCR) to follow. Please refer to the CMS 2567 along with the facility's plan of correction

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 25, 2016

Ms. Nicole Donahue, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

RE: Project Number S5320027

Dear Ms. Donahue:

On March 10, 2016, a Minimum Data Set (MDS) 3.0/Staffing Focused 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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:

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

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

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

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

Informal Dispute Resolution - 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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0970
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 April 19, 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 the following remedy will be imposed:

- Per instance civil money penalty for the deficiency cited at 314. (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. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 June 10, 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 that your provider agreement be terminated by September 10, 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have 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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	03/10/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Minimum Data Set (MDS) 3.0/Staffing Focused Survey was completed at your facility by the Minnesota Department of Health. The following deficiency(ies) are issued. The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff, if your ePoC for the respective deficiencies (if any) is acceptable.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for 2 of 5 resident (R7, R9) reviewed for unnecessary medications. Findings include: R7 was observed on 3/10/16, at 1:30 p.m. to be awake, sitting in his wheel chair. When approached and interviewed regarding the medication, Seroquel, R7 indicated he did not notice or experience any side effects from the	F 282	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:	4/19/16

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

Electronically Signed | 04/04/2016

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F 282	Continued From page 1 medication but did identify that he liked to stay in his room. During the interview R7 was observed to be relaxed with no behaviors noted. R7's care plan dated 2/1/16, identified R7 received an antipsychotic medication related to hallucinations. The care plan did addressed antipsychotic medication and direction for staff to monitor for side effects, target behaviors. However, the medical record lacked documentation of target behavior monitoring, side effect monitoring and monthly orthostatic blood pressure monitoring. R7's medical record revealed R7 had diagnoses that included Parkinson's disease, hallucinations, major depressive disorder, and insomnia. Currently medications included diazepam 2 milligrams (mg) and quetiapine fumarate 25 mg 1 tablet by mouth in the morning and 1.5 tablet by mouth at bedtime. During an interview with registered nurse (RN)-A on 3/9/16, at 1:43 p.m. R7's medical record lacked documentation of target behavior monitoring, side effect monitoring and monthly orthostatic blood pressure monitoring since admitted and indicated, "It should have been in the Treatment Administration Record [TAR] and we have been doing them and he admitted with Seroquel." During interview on 3/9/16, at 1:54 p.m. RN-B confirmed R7's medical record lacked documentation of target behavior monitoring, side effect monitoring and orthostatic blood pressure monitoring since admitted and stated, "Expectation should be per facility policy; target behavior monitoring should done every shift with	F 282	1) The medication and treatment records for R#7 and R#9 have been updated to include target behaviors, side effect monitoring and orthostatic blood pressures. 2) All residents currently receiving psychoactive medications have been reviewed to assure side effect monitoring is being completed including orthostatic blood pressures and target behaviors are appropriate to the medications administered. The medication and treatment records have been updated to reflect any changes. 3) All licensed nursing staff will receive re-education on the guidelines for monitoring psychoactive medications for side effects including orthostatic blood pressure and target behaviors for medications received. Education will be completed by April 19, 2016. 4) The Director of Nursing and/or designee will audit three (3)residents each week for one month and then two (2) residents per week for two months to assure side effect monitoring, orthostatic blood pressures are done and target behaviors monitored to assure the psychoactive medication is effective and the care plan is followed. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed	

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F 282	Continued From page 2 three non-pharmacological interventions in place, side effect of psychotic medication should be monitored, and monthly orthostatic blood pressure should be in place in the medical record." Policy and procedure title PSYCHOACTIVE MEDICATION ADVERSE EFFECT MONITORING dated 9/2013, reads, "1. A resident admitted to the facility with orders for psychoactive medications including antipsychotics, antidepressants, anxiolytics, or mood stabilizers, will be monitored using this procedure. 2. Medication monitoring will begin on the day of the medication initiated and continue for 7 days. 3. If any clinically significant adverse effect is noted within the 7 day monitoring period, nursing will update the medical provider and document in the clinical record describing the nature of the adverse effect and its potential impact on the individual's mental or physical condition or functional or psychological status. 4. If no adverse effect is noted after the initial monitoring, the resident will be assessed for 7 days per month followed by a quarterly review for consideration of continued use with documentation in the clinical record. 5. Nursing may choose to implement the monitoring tool at any time to assist in evaluating a change in resident condition. 6. The nurse will review the care plan to reflect the behavior has been identified, specific goal, and ensure interventions are in place for the medication and non-pharmacological interventions." R9 was observed seated in the wheelchair in a group activity on 3/9/16, at 3:06 p.m. R9 indicated to the nursing assistant (NA) that she was going home tomorrow.	F 282	during the monthly Quality Meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up.	

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F 282	Continued From page 3	F 282		

NA-A was interviewed on 3/9/16, at 3:06 p.m. and indicated R9 woke up that morning crying, as some days she did and some days she did not.

The Medication Administration Record (MAR) from October 2015 through February 2016, were reviewed. The MAR noted R9 received Seroquel (an antipsychotic), Celexa and Trazodone (both are antidepressants). R9 also received an anti-hypertensive medication (Lisinopril) to manage her blood pressure.

The Treatment Administration Records from October 2015 through February 2016, were reviewed. None of the months noted an orthostatic blood pressure being recorded.

R9's Resident Incident reports from 10/31/15, going forward were reviewed. Eleven incidents of falls without major injury were recorded and only three incidents had the orthostatic blood pressures completed. Of the 11 Incident reports one incident had a sitting blood pressure of 99/64.

R9's antipsychotic medication care plan revised 11/4/15, for antidepressant use, hypnotic and Seroquel use directed the staff to observe for side effects and effectiveness. Only the hypnotic plan of care directed staff to monitor for a drop in blood pressure (orthostatic blood pressure).

R9's mobility care plan dated 2/2/16, indicated R9 transferred with assist of one, ambulated with assist of one 15-200 feet daily, and when restless or attempting to self-transfer staff were offer R9 a distraction, and staff were to observe, document and report to the medical professional any

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F 282	Continued From page 4	F 282		

changes in mobility and the pharmacist was to review the medication regimen as needed.

The Weights and Vitals Summary printed on 3/10/16, noted no orthostatic blood pressures have been recorded for R9 for the month of 10/2015. On 10/22/15, the blood pressure was noted to be 95/45, and on 10/20/15 and 10/21/15, the sitting blood pressure was noted to 100/42 and 100/58.

The director of nursing (DON) and RN-B was interviewed on 3/9/16, at 3:15 p.m. Both acknowledged the resident had fallen in the past and was on an anti-hypertensive medication and antipsychotropic medications, and verified the orthostatic blood pressures had not been completed. The DON indicated R9 was ambulatory and that the resident could stand for orthostatic blood pressures.

The package insert for Seroquel from AstraZeneca dated 10/13, noted the medication "should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease or conditions which would predispose patients to hypotension (dehydration, hypovolemia and treatment with antihypertensive medications)."

The package insert for Trazodone from Kaiser Foundation Hospitals revised 5/7/14, noted, "There is a potential for hypotension, including orthostatic hypotension and syncope."

The package insert for Lisinopril from Proficient Rx LP revised 2/1/15, noted, "Patients at risk of

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F 282	Continued From page 5 excessive hypotension include those with the following conditions or characteristics: heart failure with systolic blood pressure below 100 mmHg, ischemic heart disease, cerebrovascular disease, hyponatremia, high dose diuretic therapy, renal dialysis, or severe volume and/or salt depletion of any etiology." R9 did not receive appropriate services for the psychoactive and anti-hypertensive medication according to the plan of care.	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R10) who had pressure ulcers was comprehensively re-assessed to identify risk factors so as to prevent further skin breakdown following identification of pressure ulcers. R10 sustained harm as she developed pressure ulcers to both heels and a pressure ulcer to her buttocks/coccyx area. Findings include:	F 314	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:	4/19/16

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F 314	Continued From page 6 R10 was observed at 12:53 p.m. on 3/9/16 to have very edematous feet which were wrapped with white dressings, and covered with booties. R10's right foot was observed to rest on a black strap attached to the back of the foot pedal, and her left foot was observed to rest on the hard plastic foot pedal of the wheelchair (w/c). R10 stated at that time that staff would routinely place a pillow under her heels at night, but it would fall off the bed at night, especially when she laid on her back. However R10 stated that when staff positioned her on her side, her feet stayed put on the pillow. A blue foam boot was observed on R10's stationary chair. When R10 was asked about the blue foam boot she stated she did not like to wear the boot because her foot would get tangled up in it. Review of R10's record indicated the resident had developed skin breakdown while residing in the facility. The Admission Record indicated R10 had been admitted on 2/2/16, with diagnoses including: diabetes, left foot drop and systemic Lupus. The Body Audit completed on 2/2/16, indicated R10's skin was intact with the exception of bruising on the abdomen from insulin injections. R10's Minimum Data Set (MDS) dated 2/9/16, noted R10 did not refuse care, had no behavior problems, had mild cognitive impairment, and needed assist of one for bed mobility, transfers, toileting, and ambulation. The Pressure Ulcer Care Area Assessment dated 2/10/16, noted R10 to have no open areas at that time, to make slight changes in her position independently, to be at mild risk for the	F 314	1) A Comprehensive Assessment for skin risk factors including the Braden and Turning and Repositioning Guidelines were updated for R#10. The information was documented on the resident's plan of care and the NAR Assignment Sheet. R#10 wounds continue to improve including the area identified to her buttocks/coccyx that was an injury, not a pressure ulcer. 2) All residents with current wounds will have a Comprehensive Skin Risk Assessment completed to assure all measures in place are appropriate to promote healing and prevent further breakdown. 3) All licensed nursing staff will be re-educated on completing the comprehensive Skin Risk Assessment, Braden Scale, and prevention measures. Education will be completed by April 19, 2016. 4) The Director of Nursing and/or Designee will audit three (3) residents each week for one month and then two (2) residents per week for two months to assure the plan of care for the individual resident is appropriate for promoting healing and preventing further breakdown. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed during the monthly Quality Meeting. At	

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F 314	Continued From page 7 development of skin breakdown. The PT (Physical Therapy)/OT (Occupational Therapy) Treatment Notes were reviewed from 2/23/16, going forward. On 2/24/16, the PT note indicated R10 had acquired a new blister from the AFO. The notes indicated PT had the company come and adjust the AFO on 2/25/16, and the AFO would remain off until the heel was healed. On 3/7/16, OT noted resident had been refusing foot pedals on the wheelchair. Foot rests were provided and the resident was asked to refrain from propelling the w/c with her feet. On 3/10/16, PT added to R10's exercises "w/c push-ups, to prevent sliding and shearing." R10 was also fitted with a new w/c and cushion. A Progress Note dated 2/24/16, at 1:57 p.m. indicated R10's left heel was noted to have a formed blister on it caused by the friction/shearing of the AFO. The AFO was placed on hold and the physician, dietary, and therapy were notified. The Body Audit completed that date noted 5.0 centimeter (cm) by 5.0 cm on the left outer heel blister with a small amount of serous fluid. Skin prep was to be used on the wound and the wound was to be wrapped with Kerlix (gauze dressing). The wound was staged at a Stage 2 pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The February 2016 Medication Administration Record (MAR) indicated R10 had received a multi-vitamin with zinc (ordered on 2/25/16), and Glucerna (a nutritional supplement) eight ounces three times a day for wound healing.	F 314	this time the committee will make the decision/recommendation regarding any necessary follow up.	

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F 314	Continued From page 8	F 314		

The March 2016 MAR also indicated R10 received Glucerna eight ounces three times a day for wound healing. The March 2016 Treatment Administration Record (TAR) noted the licensed staff monitored the left heel blister daily for dressing which was noted to have moderate serous drainage, the surrounding skin color was noted to be white/gray/pallor, the surrounding skin was identified as normal, and R10's pain was controlled. The TAR indicated the right heel was being monitored as of 3/5/16.

A Body Audit dated 3/2/16, noted the skin had come off of the blister on the left heel. The underside skin was pink in color and the wound had a moderate amount of drainage which was serosanguinous. The note indicated the wound was cleansed and dressed.

Wound Summary documentation dated 3/3/16, indicated the left heel wound was a Stage 2 pressure ulcer, facility acquired and was classified as a blister. The area had heavy serous drainage, was bright red or pink at 75% and had epithelial tissue at 20%. The area measured 5.0 cm by 5.0 cm by 0.0 cm. The comment section noted the physician was notified and the wound care was changed to calcium alginate (effective dressing for wounds that have exudate), cover 4 x 4 dressing and wrap with Kerlix. The comment section and medical record was void of any documentation that the facility re-assessed the wheelchair, foam boot and pillow placement at night, and mattress.

A Progress Note dated 3/4/16, at 12:30 p.m. indicated R10 asked the staff to come in the room as the resident had a blister on her right heel when she removed her stockings.

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On 3/9/16, at 1:30 p.m. RN-A was interviewed and stated R10 had an abrasion on her buttocks, but no open areas. However RN-A said she'd noticed the abrasion had bled and described the abrasion as, "it looked like a rug burn." RN-A said they had put a cream on the abrasion, but would got to "pressure ulcer type things" if the cream did not work. RN-A commented about R10, "She sits a lot, I don't know if she walks in her room or not, but she does walk with PT (physical therapy)." RN-A also stated R10 routinely slept on her back and added, "just one heel was to be floated and not the right. The right one has a blister now, I do not know where the second one came from." When RN-A was asked about R10's foot pedals she acknowledged both pedals were plastic and that there was no pressure relief support on the pedals. When asked about the black strap on the right foot pedal, RN-A stated, "that's probably where the blister [right heel] came from." RN-A also confirmed R10 did not like to use the foam boot.

During observation of R10's care on 3/9/16, at 1:40 p.m. RN-A asked R10 to transfer self from her w/c to bed. R10 was observed to scoot herself to the edge of the w/c three times, her buttocks appeared to rub against the w/c cushion before she stood. When the resident stood, RN-A assisted her to lower her pants in order to assess the area on her buttocks. R10's undergarment was noted to have bright red staining where it had covered the open area her buttocks. An open area approximately 50 cent piece size, was observed on the left buttock. The first layer of skin was missing over this area. RN-A indicated she would measure the wound and call the wound nurse. RN-A said to the surveyor,"What

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stage would you say it is?" When asked whether R10 was encouraged to get up and move/change position, RN-A said they would ask the resident, "How about if you walk now?" During this observation of care, the heels were not observed.

On 3/9/16, at 2:40 p.m. the director of nursing (DON) was asked whether she'd been informed that R10 had an open area on her buttocks to which she replied, "No." When asked how staff would identify a pressure ulcer and stage the wound the DON stated, "I did wound education following the last survey and there is a wound protocol book at the nursing station that walks you through most everything. There is a discovery sheet for new wounds on each station. They (nursing staff) were all educated on it."

On 3/9/16, at 3:04 p.m. the DON provided the surveyor with the electronic record wound documentation. When asked how R10 had received the heel wounds, the DON said she thought PT had noticed R10 propelling her wheelchair by 'walking with her feet' while she was seated in the w/c, and felt that might have been what caused the ulcer. When asked whether the DON was aware of the plastic pedals and feet placement of R10, the DON looked at the pedals and stated "I can pad them [wheelchair pedals]." In addition, the DON stated that although the electronic record indicated the clinical stage of the heel ulcers was full thickness, she could not change the documentation to identify the areas as Stage 2 which she said was what the pressure areas were for both heels. The DON stated it was "a software issue." The DON also stated R10 did not like the use of the foot pedals.

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During the additional review of R10's medical record, it was noted there was no evidence the resident's wheelchair mobility/cushion had been assessed as factors related to the friction and shearing of R10's buttocks/coccyx area prior to the surveyor having brought this to the staff's attention on 3/9/16.

R10's temporary care plan dated 2/2/16, indicated R10 had no wounds, was to be repositioned every two hours, and had a complete mattress replacement system on the bed. Facility progress notes indicated R10 was admitted with a mattress (Panacea Clinical Foam Mattress) that had a sloped heel section which redirected pressure to the resident's calves. The record failed to indicate whether the facility had attempted any alternatives when R10 refused to utilize the blue foam boot for her left heel, or when R10 couldn't keep her heels floated at night. After the surveyor brought these concerns to the DON's attention on 3/9/16, R10's mattress was replaced with a an alternating low loss mattress.

R10's care plan dated 2/15/16, indicated R10 had developed a Stage 2 pressure ulcer to the left heel from an AFO splint (ankle-foot orthosis supportive device) on 2/24/16. Interventions initiated 2/24/16 included to float heels, observe skin daily and monitor the wound. The care plan had been revised 3/9/16 to identify a Stage 2 area on the buttocks related to friction and shearing (the Wound Summary form noted the area to be on the coccyx). The care plan revision identified that the resident slides off her w/c, and that her bottom sticks to the toilet. Original care plan interventions included for the resident to be turned and reposition every three hours, more often as needed or requested. The interventions

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were revised after the information was brought to the facility's attention 3/9/16 to include, re: buttocks/coccyx remind resident to stand up from w/c without sliding, use toilet arm raisers to prevent sliding, use leg extenders, both heels to have skin prep applied, leave the right heel open to air and the left one dressed with a dressing. The care plan did not indicate that R10 refused care.

The acute skin care plan dated 3/4/16, noted R10 had a new right heel ulcer Stage 2 that measured 2.0 cm by 1.4 cm. Staff were directed to conduct weekly wound monitoring with measurements, daily wound monitoring, monitor for pain update weekly and as needed, Complete a new Braden skin assessment and skin risk factors in four weeks, notify dietary of the new ulcer and apply four layers of skin prep every shift to the area per nursing order.

The Progress Note dated 3/6/16, at 12:30 p.m. indicated R10 was sent to the hospital for a unstoppable nose bleed and the resident returned at 5:20 p.m. Information was requested regarding to the paperwork that was sent to determine whether the hospital was notified of the heel pressure ulcers and to ensure pressure relieve was provided to the resident but none could be located in the medical record.

A Progress Note dated 3/9/16, at 5:51 p.m. indicated a nursing assistant noted an open area on the resident's buttocks. The note further stated the open pressure area was related to friction to the right and left buttocks. The right buttocks redness measured 3.0 cm by 2.0 cm. The left buttocks redness measured 8.0 cm by 7.0 cm. The open area on the left buttocks measured 2.5

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F 314	Continued From page 13 cm by 2.0 cm. The NAR (Nursing Assistant Registered) Assignment Sheet dated 3/9/16, noted the resident was to have heels floated off the bed and to use the pillows. R10 was to also be turned and repositioned every two hours and as needed. The NAR sheet was void of documentation that staff were to encourage resident to make shifts in position to prevent skin breakdown, lacked evidence of resident refusals to wear foam boot, lacked evidence of staff to encourage resident not to drag bottom across the w/c cushion as to cause friction and shearing; lacked to check on pillow and heel placement while in the bed, and to elevate legs to promote healing of heel ulcers. Wound Summary documentation dated 3/10/16, noted the left heel 25% necrotic, 25% epithelialized and 50% red or bright pink. The area measured 4.20 cm by 5.30 cm with no depth. The outcome was "probable improvement." The Current Plan and Comment section noted "Area is very dry, shows improvement, 25% new tissue. Treatment changed to skin prep, dry dressing and wear Kerlix. Therapy assessed w/c positioning, new w/c with leg extenders." Even though the March TAR indicated the licensed staff monitored the left heel daily, R10's medical record lacked evidence of the left heel going from a blister to a 25% necrotic tissue to determine if the care and treatment and/or new interventions should have been reviewed and/or revised between 3/3/16 to 3/10/16, to promote healing of the left heel. The Progress Notes from 3/3/16 through 3/10/16, were reviewed and even though the facility staff did daily skilled charting, the section for Skin Integrity never identified the left heel going from a	F 314		

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blister to having necrotic tissue at 25% to determine if the care and treatment and/or new interventions should have been reviewed and/or revised between 3/3/16 to 3/10/16, to promote healing of the left heel.

Wound Summary documentation dated 3/10/16, noted the right heel to be a Stage 2 pressure ulcer caused by trauma and facility acquired. There was no drainage, area was blanchable, and had 100% erythema. The area measured 1.5 centimeters (cm) length by 1.80 width cm by 0.0 depth.

Wound Summary documentation for R10's coccyx ulceration dated 3/10/16, noted the clinical Stage to be a 2, facility acquired, caused by trauma. The area in whole measured 10.0 cm wide by 7.00 cm long and 0.0 cm depth. The Current Plan and Comment section indicated the two open areas within the larger area measured 2.5 cm by 0.5 cm and 1.0 cm by 3.5 cm. (the Progress Note dated 3/9/16 depicted the wound to be on the buttocks but the Wound Summary indicated it was on the coccyx). The note further included, "Resident slides off of w/c, therapy assessed and new w/c given resident is able to stand without sliding. Resident stated her bottom sticks to the toilet seat and she slides to move. Toilet raiser with arms on it placed so she can lift up. Pressure relieving mattress placed on bed."

The NAR (Nursing Assistant Registered) Assignment Sheet dated 3/10/16, noted the resident was to have her heels floated off the bed and to use the pillows. R10 was to also be turned and repositioned every two hours and as needed. The sheet was revised and did direct the staff to ensure R10 had the heels floated, to check

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F 314	Continued From page 15 placement of pillows, remind resident to stand straight up from chair and toilet, encourage to elevate legs and noted R10 refused to wear heel boots. The National Pressure Ulcer Advisory Panel (NPUAP) 2007, described the pressure ulcer with a necrotic (black eschar) as an "Unstageable/Unclassified: Full thickness skin or tissue loss-depth unknown full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed)." R10's left heel ulcer was not correctly staged by the facility as R10 had 25% necrotic tissue identified on the left heel which by definition would have been unstageable. The policy for Pressure Ulcer Prevention dated 10/15, revealed facility staff were to comprehensively evaluate the resident's skin throughout the stay at the facility. Staff were to determine the risk factors and evaluate the risk factors, reduce or remove the underlying risk factors, monitor the effects of the risk reduction interventions and modify when noted.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		4/19/16

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F 329	Continued From page 16 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate monitoring of an antipsychotic medication for 2 of 5 residents (R9, R7) reviewed for unnecessary medications. Findings include: R9 was observed seated in the wheelchair in a group activity on 3/9/16, at 3:06 p.m. R9 indicated to the nursing assistant (NA) that she was going home tomorrow.	F 329	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:	

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F 329	Continued From page 17 NA-A was interviewed on 3/9/16, at 3:06 p.m. and indicated R9 woke up that morning crying, as some days she did and some days she did not. The Medication Administration Record (MAR) from October 2015 through February 2016, were reviewed. The MAR noted R9 received Seroquel (an antipsychotic), Celexa and Trazodone (both are antidepressants). R9 also received an anti-hypertensive medication (Lisinopril) to manage her blood pressure. The Treatment Administration Records from October 2015 through February 2016, were reviewed. None of the months noted an orthostatic blood pressure being recorded. R9's Resident Incident reports from 10/31/15, going forward were reviewed. Eleven incidents of falls without major injury were recorded and only three incidents had the orthostatic blood pressures completed. Of the 11 Incident reports one incident had a sitting blood pressure of 99/64. R9's Fall Care Area Assessment (CAA) dated 11/2/15, indicated R9 was at risk for falls due to impaired balance during transitions and the use of an antidepressant and anti-psychotic medication. The Psychotropic Drug Use CAA indicated the resident had fallen in the past and exhibited adverse consequences of sedatives/hypnotics as indicated by the falls. The consideration for care planning was to "avoid complications." The CAA lacked evidence of any other adverse side effect monitoring. R9's antipsychotic medication care plan revised 11/4/15, for antidepressant use, hypnotic and	F 329	1) The medication and treatment records for R#7 and R#9 have been updated to include target behaviors, side effect monitoring and orthostatic blood pressures. 2) All residents currently receiving psychoactive medications have been reviewed to assure side effect monitoring is being completed including orthostatic blood pressures and target behaviors are appropriate to the medications administered. The medication and treatment records have been updated to reflect any changes. 3) All licensed staff will be re-educated on the guidelines for monitoring psychoactive medications for side effects including orthostatic blood pressures and target behaviors for medications received. Education will be completed by April 19, 2016. 4) The Director of Nursing and/or Designee will audit three (3) residents each week for one month and then two (2) residents each week for two months to assure side effect monitoring, orthostatic blood pressures are done and target behaviors monitored to assure the psychoactive medication is effective and the care plan is followed. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed during the monthly Quality Meeting. At	

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F 329	Continued From page 18 Seroquel use directed the staff to observe for side effects and effectiveness. Only the hypnotic plan of care directed staff to monitor for a drop in blood pressure (orthostatic blood pressure). The Progress Notes from 12/17/15, going forward for the consultant pharmacist (CP) review noted the CP audited R9's medication regimen on 12/17/15, 1/9/16 and on 2/11/16. The 12/17/15, not indicated "See notes to nursing on drug monitoring, and prescriber on PRN [as needed] Seroquel diagnosis." The note date 12/17/15, to nursing indicated, "5. Add orthostatic blood pressure check 1+ days a month or per facility protocol (ordered, but not being completed consistently.)" R9's mobility care plan dated 2/2/16, indicated R9 transferred with assist of one, ambulated with assist of one 15-200 feet daily, and when restless or attempting to self-transfer staff were offer R9 a distraction, and staff were to observe, document and report to the medical professional any changes in mobility and the pharmacist was to review the medication regimen as needed. R9 had a gradual dose reduction for the Seroquel on 2/16/16. The Seroquel went from 50 milligrams (mg) twice a day to 25 mg in the morning and 50 mg at bedtime per the Physician Order. Although the facility implemented a gradual dose reduction for the Seroquel, the facility still did not implement the adverse side effect monitoring for the blood pressures for R9. The Weights and Vitals Summary printed on 3/10/16, noted no orthostatic blood pressures have been recorded for R9 for the month of 10/2015. On 10/22/15, the blood pressure was	F 329	this time the committee will make the decision/recommendation regarding any necessary follow up.	

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noted to be 95/45, and on 10/20/15 and 10/21/15, the sitting blood pressure was noted to 100/42 and 100/58.

The director of nursing (DON) and the registered nurse (RN)-B was interviewed on 3/9/16, at 3:15 p.m. Both acknowledged the resident had fallen in the past and was on an anti-hypertensive medication and antipsychotropic medications, and verified the orthostatic blood pressures had not been completed. The DON indicated R9 was ambulatory and that the resident could stand for orthostatic blood pressures.

The package insert for Seroquel from AstraZeneca dated 10/13, noted the medication "should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease or conditions which would predispose patients to hypotension (dehydration, hypovolemia and treatment with antihypertensive medications)."

The package insert for Trazodone from Kaiser Foundation Hospitals revised 5/7/14, noted, "There is a potential for hypotension, including orthostatic hypotension and syncope."

The package insert for Lisinopril from Proficient Rx LP revised 2/1/15, noted, "Patients at risk of excessive hypotension include those with the following conditions or characteristics: heart failure with systolic blood pressure below 100 mmHg, ischemic heart disease, cerebrovascular disease, hyponatremia, high dose diuretic therapy, renal dialysis, or severe volume and/or salt depletion of any etiology." R9 did not receive

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F 329	Continued From page 20 appropriate adverse side effect monitoring for the psychoactive and anti-hypertensive medication R9 received. On 3/10/16, at 1:30 p.m. R7 was observed to be awake, sitting in his wheel chair. When approached and interviewed regarding the medication, Seroquel, R7 indicated he did not notice or experience any side effects from the medication but did identify that he liked to stay in his room. During the interview R7 was observed to be relaxed with no behaviors noted. R7's Admission Record dated 9/17/15, R7 had diagnoses which included Parkinson's disease, hallucinations, major depressive disorder, and insomnia. R7's care plan dated 2/1/16, identified R7 received an antipsychotic medication related to hallucinations. The care plan did address the antipsychotic medication and direction for staff to monitor for side effects, target behaviors. However, medical record lacked documentation of target behavior monitoring, side effect monitoring and monthly orthostatic blood pressure monitoring. The MAR dated 3/16, included diazepam (valium-used to treat anxiety disorders) 2 milligram (mg) and quetiapine fumarate (Seroquel) 25 mg 1 tablet by mouth in the morning and 1.5 tablet by mouth at bedtime. During an interview with registered nurse (RN)-A on 3/9/16, at 1:43 p.m. R7's medical record lacked documentation of target behavior monitoring, side effect monitoring and monthly orthostatic blood pressure monitoring since	F 329		

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admitted and indicated, "It should have been in the TAR and we have been doing them and he admitted with Seroquel."

During interview on 3/9/16, at 1:54 p.m. RN-B confirmed R7's medical record lacked documentation of target behavior monitoring, side effect monitoring and orthostatic blood pressure monitoring since admitted and stated, "Expectation should be per facility policy; target behavior monitoring should done every shift with three non-pharmacological interventions in place, side effect of psychotic medication should be monitored, and monthly orthostatic blood pressure should be in place in the medical record."

Policy and procedure title PSYCHOACTIVE MEDICATION ADVERSE EFFECT MONITORING dated 9/2013, reads, "1. A resident admitted to the facility with orders for psychoactive medications including antipsychotics, antidepressants, anxiolytics, or mood stabilizers, will be monitored using this procedure. 2. Medication monitoring will begin on the day of the medication initiated and continue for 7 days. 3. If any clinically significant adverse effect is noted within the 7 day monitoring period, nursing will update the medical provider and document in the clinical record describing the nature of the adverse effect and its potential impact on the individual's mental or physical condition or functional or psychological status. 4. If no adverse effect is noted after the initial monitoring, the resident will be assessed for 7 days per month followed by a quarterly review for consideration of continued use with documentation in the clinical record. 5. Nursing may choose to implement the monitoring tool at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	03/10/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 22 any time to assist in evaluating a change in resident condition. 6. The nurse will review the care plan to reflect the behavior has been identified, specific goal, and ensure interventions are in place for the medication and non-pharmacological interventions."	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to act upon the recommendations of the consultant pharmacist for appropriate monitoring of an antipsychotic medication for 1 of 5 residents (R9) reviewed for unnecessary medications. Findings include: R9 was observed seated in the wheelchair in a group activity on 3/9/16, at 3:06 p.m. R9 indicated to the nursing assistant (NA) that she was going home tomorrow. NA-A was interviewed on 3/9/16, at 3:06 p.m. and	F 428	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1) The medication and treatment records for R#9 have been updated to include	4/19/16

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F 428	Continued From page 23 indicated R9 woke up that morning crying, as some days she did and some days she did not. The Medication Administration Record (MAR) from October 2015 through February 2016, were reviewed. The MAR noted R9 received Seroquel (an antipsychotic), Celexa and Trazodone (both are antidepressants). R9 also received an anti-hypertensive medication (Lisinopril) to manage her blood pressure. The Treatment Administration Records from October 2015 through February 2016, were reviewed. None of the months noted an orthostatic blood pressure being recorded. R9's Resident Incident reports from 10/31/15, going forward were reviewed. Eleven incidents of falls without major injury were recorded and only three incidents had the orthostatic blood pressures completed. R9's Fall Care Area Assessment (CAA) dated 11/2/15, indicated R9 was at risk for falls due to impaired balance during transitions and the use of an antidepressant and anti-psychotic medication. The Psychotropic Drug Use CAA indicated the resident had fallen in the past and exhibited adverse consequences of sedatives/hypnotics as indicated by the falls. The consideration for care planning was to "avoid complications." The CAA lacked evidence of any other adverse side effect monitoring. R9's antipsychotic medication care plan revised 11/4/15, for antidepressant use, hypnotic and Seroquel use directed the staff to observe for side effects and effectiveness. Only the hypnotic plan of care directed staff to monitor for a drop in	F 428	target behaviors, side effect monitoring and orthostatic blood pressures. 2) All residents' currently receiving psychoactive medications have been reviewed to assure side effect monitoring is being completed including orthostatic blood pressures and target behaviors are appropriate to the medications administered. The medication and treatment records have been updated to reflect any changes. 3) All licensed nursing staff will receive re-education on the guidelines for monitoring psychoactive medications for side effects including orthostatic blood pressures and target behaviors for medications received. Education will be completed by April 19, 2016. 4) The Director of Nursing and/or Designee will audit three (3) residents each week for one month and then two (2) residents per week for two months to assure side effect monitoring, orthostatic blood pressures are done and target behaviors monitored to assure the psychoactive medication is effective and pharmacy recommendations followed. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed during the monthly Quality Meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up.	

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	245320	A. BUILDING _____ B. WING _____	03/10/2016

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F 428	Continued From page 24	F 428		

blood pressure (orthostatic blood pressure).

The Progress Notes from 12/17/15, going forward for the consultant pharmacist (CP) review noted the CP audited R9's medication regimen on 12/17/15, 1/9/16 and on 2/11/16. The 12/17/15, not indicated "See notes to nursing on drug monitoring, and prescriber on PRN [as needed] Seroquel diagnosis." The note date 12/17/15, to nursing indicated, "5. Add orthostatic blood pressure check 1+ days a month or per facility protocol (ordered, but not being completed consistently.)"

R9's mobility care plan dated 2/2/16, indicated R9 transferred with assist of one, ambulated with assist of one 15-200 feet daily, and when restless or attempting to self-transfer staff were offer R9 a distraction, and staff were to observe, document and report to the medical professional any changes in mobility and the pharmacist was to review the medication regimen as needed.

R9 had a gradual dose reduction for the Seroquel on 2/16/16. The Seroquel went from 50 milligrams (mg) twice a day to 25 mg in the morning and 50 mg at bedtime per the Physician Order. Although the facility implemented a gradual dose reduction for the Seroquel, the facility still did not implement the adverse side effect monitoring for the blood pressures for R9.

The Weights and Vitals Summary printed on 3/10/16, noted no orthostatic blood pressures have been recorded for R9 for the month of 10/2015.

The director of nursing (DON) and the registered nurse (RN)-B was interviewed on 3/9/16, at 3:15

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F 428	Continued From page 25	F 428		

p.m. Both acknowledged the resident had fallen in the past and was on an anti-hypertensive medication and antipsychotropic medications, and verified the orthostatic blood pressures had not been completed. The DON indicated R9 was ambulatory and that the resident could stand for orthostatic blood pressures.

The CP was interviewed on 3/10/16, at 11:17 a.m. and indicated she did inform the facility to monitor the resident's orthostatic blood pressure due to the current psychotic medication use. Although the CP notified the facility in 12/15, of the orthostatic blood pressures not being completed the CP did not again report the irregularity to the facility in January and February of 2016.

The package insert for Seroquel from AstraZeneca dated 10/13, noted the medication "should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease or conditions which would predispose patients to hypotension (dehydration, hypovolemia and treatment with antihypertensive medications)."

The package insert for Seroquel from Kaiser Foundation Hospitals revised 5/7/14, noted, "There is a potential for hypotension, including orthostatic hypotension and syncope."

The package insert for Lisinopril from Proficient Rx LP revised 2/1/15, noted, "Patients at risk of excessive hypotension include those with the following conditions or characteristics: heart failure with systolic blood pressure below 100 mmHg, ischemic heart disease, cerebrovascular

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F 428	Continued From page 26	F 428		

disease, hyponatremia, high dose diuretic therapy, renal dialysis, or severe volume and/or salt depletion of any etiology."

Policy and procedure title PSYCHOACTIVE MEDICATION ADVERSE EFFECT MONITORING dated 9/2013, reads, "1. A resident admitted to the facility with orders for psychoactive medications including antipsychotics, antidepressants, anxiolytics, or mood stabilizers, will be monitored using this procedure. 2. Medication monitoring will begin on the day of the medication initiated and continue for 7 days. 3. If any clinically significant adverse effect is noted within the 7 day monitoring period, nursing will update the medical provider and document in the clinical record describing the nature of the adverse effect and its potential impact on the individual's mental or physical condition or functional or psychological status. 4. If no adverse effect is noted after the initial monitoring, the resident will be assessed for 7 days per month followed by a quarterly review for consideration of continued use with documentation in the clinical record. 5. Nursing may choose to implement the monitoring tool at any time to assist in evaluating a change in resident condition. 6. The nurse will review the care plan to reflect the behavior has been identified, specific goal, and ensure interventions are in place for the medication and non-pharmacological interventions."

The facility policy for Consultant Pharmacist Duties dated 1/27/15, directed the pharmacist to review the Physician Orders and MARs to ensure proper documentation of medication orders and administration of the medications. In addition, the CP was to submit a written report to the physician

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

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F 428	Continued From page 27 and DON. The CP was to identify potential irregularities through a review of the MAR, Progress Notes, care plan, Resident Assessment Instruct, laboratory results, behavior/mood and sleep monitoring information, interviewing and observing the resident. R9 did not receive appropriate adverse side effect monitoring for the psychoactive and anti-hypertensive medication R9 received.	F 428		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XFC1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00829

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245320**

2.STATE VENDOR OR MEDICAID NO.
(L2) **679736900**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODLYN HEIGHTS HEALTHCARE CENTER**
(L4) **2060 UPPER 55TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/31/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Mandatory DPNA is effective 06/10/2016.

17. SURVEYOR SIGNATURE — Date :
Susan Miller, HFE NE II — 04/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/06/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

AMENDED LETTER

Electronically delivered
April 27, 2016

Ms Nicole Donahue, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

This letter amends and should replace the letter dated March 25, 2016.

RE: Project Number S5320027

Dear Ms. Donahue:

On March 25, 2016, we informed you that we would recommend enforcement remedies based on a Minimum Data Set (MDS) 3.0/Staffing Focused Survey, completed on March 10, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 31, 2016, the Minnesota Department of Health completed a recertification survey to verify that 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 to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E).

On April 6, CMS informed you they are imposing the following remedies:

- Federal Civil Money Penalty of $8,050.00 per instance for the instance of noncompliance at F314 (S/S: G) identified in the CMS-2567 for the survey ending March 10, 2016

- Mandatory Denial of Payment for New Admissions effective June 10, 2016

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488 Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 10, 2016. They will also notify the State Medicaid Agency that they must

also deny payment for new Medicaid admissions effective June 10, 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, Woodlyn Heights Healthcare Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 10, 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.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - 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.

Your plan of correction for the deficiencies issued at the time of the March 10, 2016 Minimum Data Set (MDS) 3.0/Staffing Focused Survey has been approved.

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0970
Telephone: (651) 201-3792
Fax: (651) 201-3790

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,

- Include electronic acknowledgement signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

- 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 https://dab.efile.hhs.gov 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
Civil Remedies Division

Attention: Nancy K. Rubenstein, Director
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 September 10, 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have 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
cc: Licensing and Certification File

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245320

April 6, 2016
By Certified Mail

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

Dear Ms. Donahue:

SUBJECT: IMPOSITION OF REMEDIES
Cycle Start Date: March 10, 2016

SURVEY RESULTS
On March 10, 2016, a MDS 3.0/Staffing Focused survey was completed at Woodlyn Heights Healthcare Center by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found that your facility was not in substantial compliance, with the most serious deficiency at scope and severity (S/S) level G cited as follows:

- F314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores.

The State agency advised you of the deficiencies that led to this determination and provided you with a copy of the survey report (CMS-2567).

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, we are imposing the following remedies:

- Federal Civil Money Penalty of $8,050.00 per instance for the instance of noncompliance at F314 (S/S: G) identified in the CMS-2567 for the survey ending March 10, 2016
- Mandatory Denial of Payment for New Admissions effective June 10, 2016

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488 Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS
Mandatory denial of payment for all new Medicare admissions is imposed effective June 10, 2016 if your facility does not achieve compliance within the required three months. This action is mandated by the Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR § 488.417(b). We will notify National Government Services that the denial of payment for all new Medicare admissions is effective on June 10, 2016. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective June 10, 2016.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

CIVIL MONEY PENALTY

In determining the amount of the Civil Money Penalty (CMP) that we are imposing, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR §488.404. We are imposing the following CMP:

- Federal Civil Money Penalty of $8,050.00 per instance for the instance of noncompliance at F314 (S/S: G) identified in the CMS-2567 for the survey ending March 10, 2016

If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted to this office within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider’s loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after <u>one</u> of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the civil money penalty.

CMP REDUCED IF HEARING WAIVED

If you waive your right to a hearing, **in writing**, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, Division of Survey and Certification, 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601-5519. **The failure to request a hearing within 60 calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.**

Any subsequent survey that results in a finding of continued noncompliance may affect the CMP. If, based on the new finding, the previously imposed CMP amount is continued or the CMP amount is changed, and you choose not to accept the new finding, it will be necessary for you to submit an additional request for a hearing on the subsequent survey finding. Alternatively, you may submit a written waiver of your right to a hearing on the subsequent survey finding.

A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 245320.
- The start date for this cycle is March 10, 2016.

TERMINATION PROVISION

If your facility has not attained substantial compliance by September 10, 2016, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at Sections 1819(h) and 1919(h) and Federal regulations at 42 CFR § 488.456 and §489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR §489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

As indicated above, a CMP which to date has accrued in the amount of $5,000 or more, is being imposed against Woodlyn Heights Healthcare Center. If you fail to request a hearing, in writing, within 60 calendar days from receipt of this letter; or if you submit a written waiver of your right to a hearing, which results in the CMP being reduced to an amount that is still $5,000 or more; or if you timely request a hearing and there is a final administrative decision upholding the CMP in the amount of $5,000 or more, your facility is subject to a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) prohibition for two years. The two-year prohibition will be effective, as applicable, with: (1) the expiration of the 60-day period for filing a written request for a hearing; or, (2) the receipt of your written waiver of the right to a hearing within the specified time period; or (3) the date of the final administrative decision upholding the CMP in the amount of $5,000 or more. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed:

- Federal Civil Money Penalty of $8,050.00 per instance for the instance of noncompliance at F314 (S/S: G) identified in the CMS-2567 for the survey ending March 10, 2016
- Mandatory Denial of Payment for New Admissions effective June 10, 2016

If you disagree with the findings of noncompliance which resulted in this imposition, 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 Federal regulations at 42 CFR §498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact

and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Nancy K. Rubenstein, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice. It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki. Failure to do so could result in our office proceeding with collection of the CMP.

INFORMAL DISPUTE RESOLUTION
The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)
In accordance with 42 CFR §488.431, when a civil money penalty subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, 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 (or why you are

disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to: www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm. This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

CONTACT INFORMATION

If you have any questions regarding this matter, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

/s/

Jean Ay
Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	03/31/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to determine if the practice of self administration of medication (SAM) was safe for 2 of 2 residents (R39 and R47) in the sample that were self administering their medications. Findings include: R47 was not assessed for the ability to self administer medications. On 3/28/16, at 6:10 p.m., registered nurse (RN)-	F 176	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:	5/6/16

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

Electronically Signed | 04/21/2016

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F 176	Continued From page 1 A was observed to administer the following medications to R47: Simvastatin 10 milligrams (mg) (a medication for high cholesterol), calcium carbonate-vitamin D 500-200 mg, acetaminophen 500 mg 2 tablets (pain medication), and Senna S (medication for constipation) 1 tab by mouth as needed twice a day for constipation. RN-A brought the medications to R47's room where R47 was sitting in a recliner and conversing on the telephone. R47 said thank you to RN-A, who then set the medications on the table next to R47, and left the room. Interview with RN-A at 6:20 p.m. indicated she did not know if R47 was assessed to self administer medications, but if a resident was alert and oriented she could leave the medications. RN-A did not indicate that she was going to check if R47 took the medications. Document review on 3/28/16 at 7:00 p.m., no self administration of medication assessment was located. On 3/28/16 at 7:05 p.m., the director of nurses (DON) stated the self administration of medication assessment was on the computer, and she verified R47 did not have one completed. She also verified that an assessment needed to be completed before the staff could leave medications at the bedside for a resident to take at a later time. R39 was not assessed for the ability to self administer nebulizer medication. During observation of medication administration on 3/12/16 at 5:55 p.m., R39 was observed to receive an albuterol nebulizer. RN-A administered Albuterol 2.5 mg (micrograms)/ 3 ml (milliliters) (medication for shortness of breath or wheezing) via nebulizer, and left the room. R39 stated "come back in ten minutes". Interview with RN-A	F 176	1) With respect to R39 and R47; the nurses providing the medications were educated on proper procedure. Residents were assessed for their ability to self-administer their nebulizer/medications after set up and a physician order was obtained. The resident care plan and Treatment Administration Records were revised accordingly. Reassessment for ability to self administer will be conducted on a quarterly basis or change of condition. 2) All residents receiving nebulizer treatments/medications were assessed to determine their ability to self-administer their nebulizer treatments/medications after set-up and a physician order was obtained when indicated. The Treatment Administration Record and care plans were revised accordingly. 3) All nursing staff will receive re-education on facility policy and procedure for self administration of medications and proper medication administration procedure. Education will be completed by May 6, 2016. 4) The Director of Nursing and/or designee will audit two residents each week for one month and one resident each week for two months for self administration of medications. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed	

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F 176	Continued From page 2 at 6 p.m., indicated the resident is able to finish the nebulizer, and she will go back in 10 minutes and remove the nebulizer. She did not stay in the room with R39. The DON stated on 3/12/16 at 7:05 p.m., that for a resident to be left alone with the nebulizer running, the resident had to have an order to self administer medications. The DON verified R39 did not have a physician's order to SAM the nebulizer after staff set up, and a SAM assessment had not been completed. Review of the facility's Medication Self Administration Safety Screen and/or Self Administration of Nebulizer's Evaluation dated Nov. 2014 indicated the following: "The Medication Self Administration Safety Screen and /or the Self Administration of Nebulizer's Evaluation is only completed if the resident requests to do their own medications or some of their own medications such as inhalers, eye drops or actual pills. Resident's that require nebulizer treatment will be assessed to determine if it is appropriate to leave alone during the nebulizer treatment. Evaluation and approval for self administration of medications will be based on the Medication Self Administration Safety Screen and/ or the Self Administration of Nebulizer's Evaluation. If a resident is being screened to determine if they can be left alone during the nebulizer treatment, facilities may complete either the Medication Self Administration Safety Screen or the Self Administration of Nebulizer's Evaluation. The Medication Self Administration Safety Screen will be completed prior to the resident initiating self administration of medications and with any medication changes, changes in	F 176	during the Monthly Quality Meeting. At this time the committee will make the decision/recommendation regarding any necessary follow-up.	

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F 176	Continued From page 3 function/condition that might affect the residents ability to safely self administer medication. On going evaluation should occur at a minimum of quarterly. The IDT will review the summary on the Medication Self Administration Safety Screen to determine appropriateness of self administration of medications. The determination will include whether the resident can self administer medications unsupervised, with supervision or is not safe to administer medications. A physician order will be obtained indication which medications the resident may self administer and with or with out supervision.	F 176		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		5/6/16

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F 278	Continued From page 4 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code Minimum Data Set (MDS) assessments for 1 of 3 residents (R53) who were reviewed for accurate MDS assessments. Findings include: During an observation on 3/28/16, at 6:44 p.m. R53 was observed with missing teeth. On 3/30/16, at 8:02 a.m. R53 was sitting in the dining room eating breakfast. When interviewed on 3/30/16, at 8:15 a.m. R53 expressed concern about partials and teeth needing repair, and not understanding why the issues had not been taken care of since the teeth have been a problem for some time. Document review of a form dated 4/30/15, and titled Dental Chart Progress Notes, read, "Treatment recommendations: Filling, extractions, and fabrication of upper full denture. Alternatives to treatments include no extractions and fabrication of new upper partial, however this has a questionable prognosis. Treatment options discussed with patient. Reviewed with patient the examination findings, diagnosis; treatment options, benefits, risks, limitations, as well as	F 278	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1) With respect to R53 an oral screen was completed and dental recommendations from the oral health screen were presented to the family for making determination for treatment. The MDS was corrected, care plan updated and NAR Assignment Sheet revised accordingly. 2) All resident records have been audited by Health Information to ensure they have been offered dental care/services within the past 12months. Dental status has been determined. Resident care plans and NAR Assignment Sheets updated and MDS coding corrected if indicated.	

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F 278	Continued From page 5 prognosis. Exam every 6 months., Prophy every 3 months:" Document review of a form dated 3/28/16, titled Dental Chart Progress Notes, read, "Moderate generalized chronic periodontitis, Non restorable upper teeth caries requiring restoration." Document review of the 1/21/16,annual Minimum Data Set (MDS) read, "Broken or loosely fitting full or partial denture: No. Obvious or likely cavity or broken natural teeth; No." The health unit coordinator (HUC) on 3/30/16, at 2:00 p.m. verified the dental referral form had not been communicated to F53's guardian. The HUC did not know why the guardian was not contacted and could not find any documentation in the medical record to explain why R53 had not received the services recommended by the dentist on 4/30/15. On 3/30/16, at 3:00 p.m. registered nurse RN-C verified the MDS was inaccurate and the dental issues should have been identified on the annual MDS assessment dated 1/21/16. RN-C verified R53 clearly had broken and missing teeth at the time of the annual assessment.	F 278	3) All nursing staff will receive re-education by May 6, 2016 on the guidelines and process for dental visits, completing the Oral/Dental Assessment, updating the care plan regarding dental status and NAR Assignment Sheet. 4) The Director of Nursing and/or Designee will complete two resident chart audits each week for one month and then one resident chart audit per week for two months to assure dental services are offered and obtained as requested, the MDS, care plan and NAR Assignment Sheet reflect the resident's dental status. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discuss during the monthly Quality meeting. At this time the committee will make the decision/recommendation regarding any necessary follow-up.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		5/6/16

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F 280	Continued From page 6 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 1 of 2 residents (R77) who was reviewed for accidents. Findings include: R77 was identified as a fall risk and the facility failed to update the current care plan to reflect changes in the resident. Incident reports were requested and reviewed. 1. On 2/13/16 at 4:30 p.m., R77 fell while being transferred to the toilet by a nursing assistant (NA)-H. R77 had an unsuccessful transfer and was assisted to the floor. Contributing factor identified on the fall investigation sheet indicated poor transfer procedure by NA-H. R77 was transferred from wheelchair to the toilet while only wearing socks. No gait belt was used during the time of transfer. Interventions at that time included staff	F 280	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1) With respect to R77, all incidents in the past three months have been reviewed, a falls risk assessment completed and plan implemented in regards to falls risk. R77's care plan and the NAR Assignment Sheet were updated to reflect interventions implemented. 2) All residents with falls in the past three	

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	245320	A. BUILDING _____ B. WING _____	03/31/2016

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F 280	Continued From page 7 re-education; reminded to use gait and seek assistance if necessary when transferring residents. Physical therapy evaluation and treatment were requested. 2. On 2/15/16 at 4:15 p.m., R77 was being transferred from toilet to the wheelchair by NA-H and R77's feet slid out from under her. R77 was assisted to the floor by NA-H. R77 was transferred with the use of a gait belt, however the slippers did not have a nonskid sole. Intervention included family would bring in different footwear and physical therapy to evaluate and treat. 3. On 3/26/16 at 5:30 p.m. R77 was lowered to the floor in the bathroom by NA-H during a transfer. The Fall Investigation form indicated the fall was intercepted and R77 lowered to the floor after using the toilet. R77 was wearing socks and a gait belt was not in use during the time of transfer. Review of the cause of the fall indicated the resident had a decrease in physical function and was unable to stay standing from lack of strength. Interventions to prevent further falls included staff re-education on toileting and assistance from other staff. Resident to be assist of two with all transfers. Resident to continue to work with physical therapy. Review of progress notes indicated the following: 2/15/16 Summoned to room by NAR {nursing assistant register}. {R77's name} slippers slid on the tile of the bathroom during transfer from toilet to wheelchair. NAR controlled the descent. No head strike.	F 280	months have been reviewed to assure a Falls Risk Assessment has been completed, the care plan revised to include any changes and the NAR Assignment Sheet updated with those changes as indicated. 3) Nursing staff will receive re-education on facility procedure for completing a Falls Risk Assessment, interventions appropriate to determining the root cause and revisions to care plan and NAR Assignment Sheet. Education will be completed by May 6, 2016. 4) The Director of Nursing and/or Designee will complete two Accident Prevention Audits each week for one month and then one audit every week for two months to assure the Fall Assessment is completed, NAR Assignment Sheet and Care Plan updated to reflect interventions. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed during the monthly Quality Meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up.	

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F 280	Continued From page 8 3/26/16 "Resident lost strength while transferring from the toilet and was assisted to the floor. No injury/ies sustained. VSS BP (vital signs stable) blood pressure, T97.4, P93, R18, 02Sats 98 RA {room air} Staff present at the time of fall. care plan followed." The current care plan in the medical record was updated on 2/15/16 and indicated the daughter would bring in non slip footwear. Transfers remained at requires 1 staff assistance to transfer. On 3/26/16 the care plan was updated with intervention to use gait belt with all transfers and assist of two with transfers and ambulation. On 3/31/16 at 11:45 a.m. the assistant director of nursing (ADON) on 3/31/16 at 11:45 a.m., was interviewed and verified that after the fall on 2/15/16, the care plan should have been updated to transfer R77 with assist of two staff persons and it was not updated until 3/26/16. The ADON verified the nursing assistant kardex, dated 3/30/16 had not been updated to reflect the change in transfers.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for 1 of 2 residents (R36) identified as having a	F 282	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	5/6/16

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F 282	Continued From page 9 pressure ulcer. Findings include: The director of nurses (DON) stated during an interview on 3/29/16, at 3:53 p.m. R36 had a newly acquired pressure ulcer, which was close to being healed. The care plan revised on 3/25/16, identified R36 had a pressure ulcer and another section of the care plan revised on 2/6/15, directed staff to reposition R36 every three hours. R36 was observed from 8:23 a.m. to 12:32 p.m. on 3/30/16, a total of 4 hours and nine minutes, and was not repositioned. On 3/30/16, at 11:40 a.m. the assistant director of nurses (ADON) indicated having looked at R36's pressure ulcer at around 7:30 a.m. on this date and the area was healed. The ADON stated a Wound Assessment Details Report had been completed. A review of the 3/30/16, Wound Assessment Details Report indicated the coccyx was healing, with 75% intact skin and no open area was present at the time. When interviewed on 3/30/16, at 12:15 p.m. NA-C could not remember if R36 had been repositioned since getting R36 up at 7:30 a.m. that morning. NA-C explained being, "everywhere" on the unit that morning. On 3/30/16, at 12:28 p.m. nursing assistant (NA)-D stated NA-C had gotten R36 up that morning and NA-D had only assisted NA-C in transferring R36 from the bed to the wheelchair that morning. At this time the administrator was	F 282	as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1) A Comprehensive Skin and Positioning Evaluation including the Braden was completed for R36. The information was documented on the resident's plan of care and the NAR Assignment Sheet. R36 wound is improving and closed x2 weeks. The identified staff responsible for repositioning has received education on following the repositioning schedule and rationale. 2) All residents with current wounds will have a comprehensive Skin and Positioning Evaluation completed to assure all measures in place are appropriate to promote healing and prevent further breakdown. 3) All nursing staff will receive re-education on completing the Comprehensive Skin and Positioning Evaluation, accuracy of the Braden to determine risk, revising the care plan and NAR Assignment Sheets to identify and implement intervention and accuracy of the Braden to determine risk, revising the care plan and NAR Assignment Sheets to identify and implement interventions. Education will be completed by May 6,	

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F 282	Continued From page 10 informed R36 had not been repositioned for greater than four hours.	F 282	2016. 4) The Director of Nursing and/or Designee will audit two residents each week for one month and then one resident per week for two months to assure the plan of care for the individual resident is appropriate for promoting healing and preventing further breakdown. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed during the monthly Quality Meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary treatment and services to 1 of 2 residents (R36) identified as having a pressure ulcer.	F 314	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the	5/6/16

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F 314	Continued From page 11 Findings include: The director of nurses (DON) stated during an interview on 3/29/16, at 3:53 p.m. R36 had a newly acquired pressure ulcer, which was close to being healed. Review of a Wound Assessment Details Report dated 3/25/16, revealed R36 had developed a superficial pressure ulcer on the coccyx, measuring 1 centimeter (cm) by 1.1 cm. A Wound Assessment Details Report dated 3/30/16, and completed at 7:08 a.m. indicated the areas was healing and there was 75% intact skin with no open area present at the time. The care plan revised on 3/25/16, identified the pressure ulcer. Another section of the care plan revised on 2/6/15, and an undated nursing assistant assignment sheet indicated R36 was to be repositioned every three hours. However, based on observation, R36 was not repositioned from 8:23 a.m. to 12:32 p.m. on 3/30/16, a total of 4 hours and nine minutes. On 3/30/16, at 11:40 a.m. the assistant director of nurses (ADON) indicated having looked at R36's pressure ulcer at around 7:30 a.m. on this date. The ADON verified the pressure ulcer was closed and a Wound Assessment Details Report had been completed and dated 3/30/16. NA-C reported on 3/30/16, at 12:15 p.m. not remembeing if R36 had been repositioned since getting R36 up at 7:30 a.m. that morning. NA-C explained being, "everywhere" on the unit that morning.	F 314	facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1) A comprehensive Skin and Positioning Evaluation including the Braden was completed for R36. The information was documented on the resident's plan of care and the NAR Assignment Sheet. R36 wound is improving and closed x2 weeks. The identified staff responsible for repositioning has received education on following the repositioning schedule and rationale. 2) All residents with current wounds will have a Comprehensive Skin and Positioning Evaluation completed to assure all measures in place are appropriate to promote healing and prevent further breakdown. 3) All nursing staff will receive re-education on completing the comprehensive Skin and Positioning Evaluation, accuracy of the Braden to determine risk, revising the care plan and NAR Assignment Sheets to identify and implement interventions. Education will be completed by May 6, 2016. 4) The Director of Nursing and/or Designee will audit two residents each week for one month and then one resident	

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F 314	Continued From page 12 On 3/30/16, at 12:28 p.m. nursing assistant (NA)-D stated NA-C had gotten R36 up that morning and NA-D had only assisted NA-C in transferring R36 from the bed to the wheelchair that morning. The administrator was informed that R36 had not been repositioned for greater than four hours. On 3/30/16, at 12:32 p.m. R36 was transferred, with the use of an EZ-stand lift and two staff, from the wheelchair into the bed. According to licensed practical nurse (LPN)-C, R36's incontinent brief was wet and R36 had been incontinent of urine and stool. Observation of R36's coccyx area during pericare care revealed a scabbed area on the coccyx; and the skin on the buttocks and coccyx blanched within minutes of having been turned on the right side.	F 314	per week for two months to assure the plan of care for the individual resident is appropriate for promoting healing an preventing further breakdown. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed during the monthly Quality Meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provided the necessary care and services to 1 of 2 residents (R77) to minimize the risk of falls. Findings include:	F 323	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of	5/6/16

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F 323	Continued From page 13 R77 was identified as a fall risk and the facility failed to update the current care plan to reflect changes in the resident. On 3/30/16 at 1:48 p.m. R77 was transferred with a pivot transfer and two nursing assistants to the toilet. R77 was able to void on the toilet. Nursing assistant (NA)-D indicated R77 was dry and needed to be transfered with the assist of two staff. The quarterly minimum data set (MDS) dated 1/21/16 identified R77 with sever impaired cognition with short and long term memory concerns, and required extensive assist of one staff person for all transfers. The MDS indicated the resident had not had any falls since admission or since the prior assessment. Morse Fall Scale 10-14 was completed on 2/15/16 and indicated R77 had a score of 75. High risk was considered 45 and higher. During the staff interview on 3/28/16 at 6:35 p.m. the staff nurse indicated the resident had not had any falls. During a family interview on 3/29/16 at 8:30 a.m. family member (F)-A, indicated R77 had several falls and questioned the cause of the falls. Incident reports were requested and reviewed. 1. On 2/13/16 at 4:30 p.m., R77 fell while being transferred to the toilet by a nursing assistant (NA)-H. R77 was assisted to the floor. Contributing factor identified on the fall investigation sheet indicated poor transfer procedure by NA-H. R77 was transferred from wheelchair to the toilet while only wearing socks.	F 323	deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1) With respect to R77, all incidents in the past three months have been reviewed, a falls risk assessment completed an plan implemented in regards to falls risk. her care plan and the NAR Assignment sheet were updated to reflect interventions implemented. 2) All residents with falls in the past three months have been reviewed to assure a Falls Risk Assessment has been completed, the care plan revised to include any changes and the NAR Assignment Sheet updated with those changes as indicated. 3) All Nursing Staff will receive re-education on procedure for completing Falls Risk Assessment, interventions appropriate to determining the root cause and revisions to care plan and NAR Assignment Sheet. Education will be completed by May 6, 2016. 4) The Director of Nursing and/or Designee will complete two Accident Prevention Audits each week for one month and then one audit every week for two months to assure the Fall Assessment is completed, NAR Assignment Sheet and Care Plan updated to reflect interventions.	

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F 323	Continued From page 14 No gait belt was used during the time of transfer. Interventions at that time included staff re-education; reminded to use gait and seek assistance if necessary when transferring residents. Physical therapy evaluation and treatment were requested. 2. On 2/15/16 at 4:15 p.m., R77 was being transferred from toilet to the wheelchair by NA-H and R77's feet slid out from under her. R77 was assisted to the floor by NA-H. R77 was transferred with the use of a gait belt, however the slippers did not have a nonskid sole. Intervention included family would bring in different footwear and physical therapy to evaluate and treat. 3. On 3/26/16 at 5:30 p.m. R77 was lowered to the floor in the bathroom by NA-H during a transfer. The Fall Investigation form indicated the fall was intercepted and lowered to the floor after using the toilet. R77 was wearing socks and a gait belt was not in use during the time of transfer. Review of the cause of the fall indicated the resident had a decrease in physical function and was unable to stay standing from lack of strength. Interventions to prevent further falls included staff re-education on toileting and assistance from other staff. Resident to be assist of two with all transfers. Resident to continue to work with physical therapy. Review of progress notes indicated the following: 2/15/16 Summonsed to room by NAR {nursing assistant register}. {R77's name} slippers slid on the tile of the bathroom during transfer from toilet	F 323	5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed during the monthly Quality Meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up.	

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F 323	Continued From page 15	F 323		

to wheelchair. NAR controlled the descent. No head strike.

3/26/16 "Resident lost strength while transferring from the toilet and was assisted to the floor. No injury/ies sustained. VSS BP (vital signs stable) blood pressure, T97.4, P93, R18, 02Sats 98 RA {room air} Staff present at the time of fall. care plan followed."

The current care plan in the medical record was updated on 2/15/16 and indicated the daughter would bring in non slip footwear. Transfers remained at requires 1 staff assistance to transfer. On 3/26/16 the care plan was updated with intervention to use gait belt with all transfers and assist of two with transfers and ambulation.

On 3/31/16 at 11:45 a.m. the assistant director of nursing (ADON) on 3/31/16 at 11:45 a.m. The ADON verified there were no progress notes in the medical record regarding a fall on 2/13/16. The ADON was unsure why there were no progress notes. The ADON did verify that after the fall on 2/15/16, the care plan should have been updated to transfer assist with two staff persons and it was not updated until 3/26/16. The ADON verified the nursing assistant kardex, dated 3/30/16 had not been updated to reflect the change in transfers.

The facility's Fall Risk and Prevention Guidelines, effective 2014, indicated a Morse Fall Scale is required after any fall in/out of the facility. It instructed the interdisciplinary team to "update the care plan and the NAR assisgngment to reflect changes in risk factors and/or individualized interventions.

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F 323	Continued From page 16	F 323		
F 353 SS=E	. 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient	F 353	The preparation of the following plan of correction for this deficiency does not	5/6/16

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F 353	Continued From page 17 staffing was provided to meet the individual needs of 1 of 2 residents (R36) for pressure ulcers, 1 of 2 residents (R77) reviewed for accidents and who did not receive assistance from staff at meal time, 1 of 3 residents (R53) reviewed for dental services and 11 of 14 (R44, R41, R110, R35, R60, R84, R96, R6, R113, R33, R111) residents observed for medication administration, who received morning medications late. Findings include: Refer to F280: The facility failed to ensure the plan of care was updated to ensure R77 was transferred in a safe manner. Refer to F314: The facility failed to ensure R36 was positioned to promote healing and prevent deterioration of pressure ulcers. Refer to F323: The facility failed to ensure R77 received the care and services to prevent falls. Refer to F412: The facility failed to ensure R53 received dental services Observation: Observations were made on 3/29/16 at 8:50 a.m. of breakfast on the memory unit. Eight residents were in the dining room and one nursing assistant was bringing residents to the tables. During breakfast meal on 3/29/16 at 8:50 a.m., family member (F)-A was present feeding R77. (F)-A left the unit at approximately 8:52 a.m. and returned with a housekeeping staff who was bringing in clean personal care covers. The housekeeping staff passed out the cloth covers	F 353	constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1) With respect to the identified areas of concern: medication administration times have been reviewed as well as resident care assignments. Times and assignments have been appropriately changed to more evenly distribute duties over the course of the day. 2) All medication pass times and NAR Assignments have been reviewed with revisions as necessary for distributing duties throughout the course of each day as able. 3) All nursing staff will receive education regarding the changes and procedure for reporting when case loads exceed capability. Education will be completed by May 6, 2016. 4) The Director of Nursing and/or Designee will complete one medication pass audit each week for one month and then one medication pass audit every other week for two months to assure medications are administered within the appropriate time frames. The Director of Nursing and/or Designee will complete	

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F 353	Continued From page 18 and restocked the storage cabinet. F-A sat down next to R77 and assisted with getting breakfast ready i.e. adding sugar to coffee. F-A then encouraged two other residents at the table to eat breakfast. F-A pulled a plate closer for one resident and handed a bowl of hot cereal to another. A resident requested more milk and F-A informed NA-K of the request. NA-K was sitting at another table feeding a resident. No additional staff were in the dining room at the time. INTERVIEWS; On 3/28/16 at 12:00 p.m. the initial tour of the memory unit revealed only one nursing assistant in the dining room with approximately 8 residents. The nursing assistant (NA)-C indicated she was the only one scheduled on the unit at this time. NA-C indicated in the past she has been the only nursing assistant on the unit. NA-C reported it is at times difficult to get all of the work done. At approximately 12:15 p.m. another nursing staff came to unit to assist with feeding residents. On 3/29/16 at 4:00 p.m. TMA/NA-J (trained medication administrator/nursing assistant) was working on the memory unit and was assigned to pass medications. TMA/NA-J indicated there were approximately 10 residents on the unit, one had just returned from the hospital and there was also one resident on hospice. TMA/NA-J was responsible for helping with the residents being at least 5 required residents required assist of two staff. During interview, on 3/30/16 at 9:47 a.m., TMA/NA-C explained that she was still passing	F 353	two resident care audits each week for one month and then one audit per week for two months to assure resident cares are completed as assigned. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed during the monthly Quality Meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up.	

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medications as because of being busy getting residents up in the morning. The TMA/NA-C added one resident was on hospice and tried to stay on top of her medications and another resident had just returned from the hospital. TMA/NA-C indicated it would take approximately 45 minutes to complete the medication pass. When asked at 11:40, TMA/NA-C indicated being finished with the med pass, but was not sure what time she completed it.

On 3/28/16 at 8:30 a.m. a family member indicated the unit needed more help. The family member reported at meal time residents have to wait for food and assistance with the meal. The family member explained that she walked around, encouraging residents to eat and reported that at meal time there is often just one staff person in the dining area.

3/30/16 at 10:39 a.m. nursing assistant (NA)-D reported trying to do her best every day, but today she was unable to assist with breakfast as she was still getting residents up for the day. "I try to do extra things, like walk residents, when others go to church after breakfast."

3/31/16 at 11:00 a.m. the scheduling staff person verified there was only one nursing assistant/trained medication assistant (TMA/NA) on the memory care unit on 3/28/16 during the day shift. There was a call in on 3/28/16, and the unit was not covered. The scheduling staff person indicated if someone calls in from the downstairs unit, they pull from upstairs and staff the memory unit with two nursing assistants with one being a trained medication assistant (TMA). If they could not fill the upstairs position, the group or the staff person pulled would be split. On

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F 353	Continued From page 20 3/31/16 during the day shift, the facility was short one nursing assistant and a group on the long term care unit had to be split. The staff person indicated the memory unit used to have two nursing assistants and then one NA would float elsewhere, but explained that about three weeks ago, because of the census on the unit, that stopped. The facility currently had a full time day nursing assistant position and a .5 night nursing assistant position open. When having difficulty filling the open shifts, the DON assists in asking staff to work and often times would work a shift herself. The scheduling staff person indicated there was only one open position to fill for nursing for the next seven days. On 3/30/16, from 8:23 a.m. to 12:25 p.m. R36, who was identified as having a recent pressure ulcer on the coccyx, was not repositioned On 3/30/16, at 6:10 a.m. nursing assistant (NA)-F shook head "no" when asked if there were enough staff on at night to complete the work. NA-F stated there was not enough staff at night to get "night cares" done. When asked what "night cares" meant, NA-F explained it was cares that included bathing a resident from head to toe. NA-F stated sometimes they could only able to do pericare for residents. NA-F stated R39 was a resident the night shift was assigned to bathe and get up in the morning. NA-F stated sometimes night staff did not have time to get the resident up in the morning and could only provide get pericare. NA-F stated it was, "hit or miss" with getting R39 up. At 6:31 a.m. NA-F also stated that charting did not always get done because there was no time left in the shift. A review of the staffing schedule for the night shift	F 353		

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dated 3/28 to 3/31/16, revealed R39 was listed as a resident the night staff were responsible for getting up before the end of the shift.

On 3/30/16, at 6:27 a.m. NA-G shook head "no" when asked if there was enough staff. NA-G explained that sometimes there was enough staff and sometimes not enough.

On 3/30/16, at 10:00 a.m. TMA/NA-C was observed passing medications. When asked if the medications were part of the morning med pass TMA/NA-C stated they were. TMA/NA-C explained that the medication pass was started on time in the morning, but since they were responsible to assist four residents to get up in the morning, the medication pass would be delayed so that the residents could be assisted. TMA/NA-C stated also needed to assist the other NA on the unit with transfers for residents requiring a two person transfer. TMA/NA-C stated there were currently four of the 12 residents on the 200 hallway which required a two person transfer. At 10:02 a.m. TMA/NA-C stated administrative staff wanted to pull her from the 200 hallway on this date to help pass medications on the upper floor, as medications were being administered late on the other floor. TMA/NA-C stated she had informed administrative staff she still had medications to pass on the 200 hallway. TMA/NA-C stated that on 3/28/16, being the only staff member on the 200 hallway and no one else had been assigned to the hallway. A review of the staffing schedule for the 200 hallway on 3/28/16, revealed only TMA/NA-C had been assigned to the hallway.

11 of 14 residents on the 400 hallway did not receive their 8 a.m. medications within the

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F 353	Continued From page 22 scheduled time. On 3/30/16 at 9:15 a.m., R44 approached a surveyor and indicated not receiving her scheduled 8:00 a.m. medications. Review of the 400 hallway's medication administration record, indicated numerous residents had not received their medications. At 9:20 a.m., the director of nursing (DON) was interviewed and she indicated she would talk to the nurse that was supposed to be administering the medications, and indicated the nurse had until 9:30 a.m. to complete the medication pass. The DON immediately returned and indicated she was going to start the medication pass, and another nurse would be assisting her. At 9:38 a.m., Registered Nurse (RN)-C administered R41 her medications. R 41 received her scheduled 8 a.m. medications, which included Acetaminophen 500 mg,(pain medication ordered 3 times a day) Albuterol Sulfate nebulizer (medication for breathing ordered 3 times a day), Senna-S (medication for constipation, ordered daily), and a Multivitamin. At 9:52 a.m., RN-C administered R110's 8:00 a.m. medications. R 110 received one Senna-S tablet (medication for constipation ordered twice a day). At 10:00 a.m., the DON administered R35's 8:00 a.m. medications. R35 received Psyllium Powder (medication ordered once a day for ischemic colitis), Vitamin D (ordered daily for Vitamin D Deficiency), multivitamin with minerals (ordered once a day for supplement), Acetaminophen (two tablets ordered twice a day for pain), Lactobacillus (one tablet ordered twice a day),	F 353		

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Ferrous Sulfate (one tablet ordered two times a day for anemia), Metoprolol (1/2 tablet ordered daily for atrial fibrillation [irregular heartbeat]), Hydroxyurea (1 tablet ordered twice a day for polycythemia vera [disorder of the bone marrow which causes too many red blood cells]) and Lisinopril (one tablet ordered twice daily for high blood pressure).

At 10:25 a.m., licensed practical nurse (LPN)-A administered R44's 8:00 a.m. medications. R44 received Lopressor (1/2 tablet ordered twice daily for high blood pressure) Aspirin (one tablet ordered for cerebrovascular disease), Claritin (one tablet ordered daily for itching), Plavix (one tablet ordered daily for blood clotting), Spiriva (inhaler ordered daily for chronic obstructive disease), Vitamin D (one capsule ordered daily for Vitamin D deficiency), Zoloft (one tablet ordered daily for major depressive disorder), Primidone (one tablet given twice a day for involuntary movements), Ropinirol (one tablet ordered three times a day for restless legs).

At 10:32 a.m., LPN-A administered R60's 8:00 a.m. medications. R60 received Lisinopril (one tablet once a day for high blood pressure), aspirin (one tablet once a day for aortic valve disorders), Potassium Chloride (one tablet daily for congestive heart failure), Coreg (one tablet twice a day for high blood pressure), and Lasix (one tablet twice daily for heart failure).

At 10:35 a.m., LPN-a administered R84's 8:00 a.m. medications. R84 received Miralax (ordered once a day for constipation, Vitamin D (ordered once a day for a supplement), Calcium (ordered twice a day for osteopenia),Dulera Aerosol (ordered 2 puffs twice a day), Oxycodone

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(narcotic ordered one tablet twice a day for pain), and Senna (one tablet twice a day for constipation,

At 10:50 a.m.LPN-A administered R96's 8:00 a.m. medications. R96 received Potassium Chloride (one tablet ordered once a day for low potassium), Ferrous Sulfate (one tablet ordered one time a day for anemia), Acidophillus (one capsule once a day for gastrointestinal health), Atenolol (one tablet ordered once a day for high blood pressure), Enalapil (one tablet ordered once a day for high blood pressure), Miralax (ordered once a day for constipation), Tylenol (two tablets ordered twice a day for arthritis), Calcium with Vit D (one tablet ordered twice a day for osteopenia), Memantine (one tablet ordered twice a day for dementia), and Restasis eye drops (one drop ordered in each eye twice a day for dry eyes).

At 11:00 a.m., LPN-A administered R6's 8:00 a.m. medications. R6 received Protonix (one tablet ordered daily), Dicyclomine (one tablet ordered twice a day for irritable bowel syndrome), Pediatric Multiple Vitamin (one tablet ordered daily), Baclofen (one tablet ordered twice daily for neuromuscular dysfunction of bladder), Oxybutynin (one tablet ordered twice daily for overactive bladder), Tylenol (two tablets ordered three times a day for pain), Maalox (ordered three times daily after meals), Lasix (one tablet ordered daily), Amlodipine (one tablet ordered daily for high blood pressure), and Aspirin (one tablet ordered daily).

At 11:15 a.m., LPN-A administered R113's 8:00 a.m. medications. R113 received Lisinopril (one tablet ordered once a day), Bupropion (two

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tablets ordered daily for anxiety), Duloxetine (one capsule ordered once day for depressive disorders), Carbidopa-Levodopa (1.5 tablet ordered three times a day for Parkinson Disease), and Divalproex Sodium (one tablet ordered every 8 hours).

At 11:24 a.m., LPN-A administered R33's medication. R33 received Lasix (one tablet ordered daily for high blood pressure), Lithium (three capsules ordered in the morning for bipolar disorder), Magnesium (2 tablets ordered daily for disorders of magnesium metabolism), Multivitamin (one tablet ordered daily for a supplement), Omeprazole (one capsule ordered daily for gastro-esophageal reflux), Synthroid (one tablet ordered before breakfast for hypothyroidism), Venlafaxine (one tablet ordered once a day for bipolar disorder), and Calcium Carbonate-Vitamin D (one tablet order three times a day for osteoporosis).

At 11:35 a.m., LPN-A administered R111's medications. R111 received Clopidogrel (one tablet daily for arteriosclerotic heart disease), Fluoxetine (one capsule ordered once a day for depression), Lasix (one tablet ordered once a day), Pantoprazole Sodium (once tablet ordered daily for Gastroesophageal reflux disease), Metoprolol (one tablet ordered twice a day for high blood pressure), Potassium Chloride (one tablet ordered twice a day for diastolic heart failure), Guaifenesin (one tablet ordered twice a day for a cough), Fluticasone-Salmeterol Aerosol (one puff ordered twice a day), and Tiotropium Bromide (one capsule ordered once a day), Azelastine HCL Solution (two sprays ordered twice a day. R111 received an Albuterol Nebulizer (ordered four times a day). LPN-A

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documented the noon nebulizer was given and not the 8:00 a.m. nebulizer because by the time the morning nebulizer was given, it was closer to the noon dose.

Interview with R44 and R84 at 11:00 a.m. on 3/30/16 indicated "certain nurses and TMAs (trained medication administrator) are always on time and certain nurses are always late. When a certain nurse works, we always get our meds late, 11:00 a.m. to 11:30 a.m."

Interview with R6 at 11:05 a.m. on 3/30/16, she stated "When I have a nurse, they are always late, when I have a TMA I get my pills by 9:00 a.m."

Interview on 3/30/16 at 11:40 a.m. with LPN-A, indicated it is "very tough" to get the medication pass done by 9:30 a.m. She indicated if there is just a nurse working, the nurse has to do treatments, medications, vitals, orders (physician orders) calls (telephone calls to families and/or physicians), and charting for 26 residents, and if there is a TMA on the opposite hallway, the nurse has to do blood sugars, insulin and treatments for those hallways. LPN-A stated "if any little glitch, I can't get done by 9:30 a.m.. LPN-A indicated that she thought the case load had "gotten harder is the past few months."

Review of the undated Woodlyn Heights Medication Administration Policy received on 3/30/16 at 12:35 p.m., indicated the following: Guideline: All residents will receive the right medication in the right does at the right time as outlined in the Physician's orders. Medications will be properly documented. Medications are not to be borrowed from other residents: refer to

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F 353	Continued From page 27 facility emergency medication list for content. Procedure: 15. Chart the medication on the Medication Administration Record immediately after it has been given. Medications should be given with a window of 1 1/2 hour before or 1 1/2 hour after the designated time, unless physician ordered at a specific time or schedule. If medication administration is given early or delayed for some reason, initial on MAR, circle the initial, and write time actually given on back side of MAR along with reason. R79, R111, R33, and R6 reported insufficient staffing concerns within the facility. R79's quarterly minimum data set (MDS) dated 12/31/15, revealed R79's cognition was intact and required extensive one to two person assist with most activities of daily living. During an interview on 3/29/16, at 9:54 a.m. R79 reported the facility was short staffed, stating they don't have enough help when they get new patients. R79 further indicated many times she had to wait a couple hours for help. R111's MDS discharge assessment-return anticipated record dated 3/6/16, revealed R111 required one person assist with most activities of daily living. During an interview on 3/29/16, at 10:31 a.m. R111 reported waiting an hour for assistance during the day and indicated most of the time it took 20 minutes to half an hour for assistance. On 3/30/16, at 8:31 a.m., during survey, R111 stated call lights were being answered quicker.	F 353		

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R33's annual MDS dated 1/15/16, revealed R33's cognition was intact and required extensive one person assist with most activities of daily living.

During an interview on 3/28/16, at 5:01 p.m. R33 stated when the facility had call-ins there would not be enough staff that day. R111 also stated it happened too often and further indicated at shift change staff did not respond as soon as they should.

R6's quarterly MDS dated 2/12/16, revealed R6's cognition was intact and required one to two person assist with most activities of daily living.

During an interview on 3/28/16, at 4:36 p.m. R6 stated waiting an hour for help last week during shift change. R6 further stated when a nursing assistant goes on break nobody covers during that time.

On 3/30/16, at 8:29 a.m., during survey, R6 indicated the call light had been answered timely.

During an interview on 3/30/16, at 10:40 a.m. when asked if she could complete her duties during the shift, nursing assistant (NA)-I stated it depended upon whether they were short or not during shift. When they were not short, she could get her work done.

During an interview on 3/31/16, at 9:56 a.m. when asked if she could complete her duties during the shift, licensed practical nurse (LPN)-D stated she was working late from the overnight shift due to a new resident's cares which took 45 minutes to complete. LPN-D stated they were short a day nurse and indicated the afternoon shift nurse would be coming in early to relieve her. They

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 29 were also short staffed today with a nursing assistant call-in. LPN-D further stated at one time they had three nurses on shift, but one nurse was removed from the schedule due to census. In the past LPN-D had voiced staffing concerns to management but was informed the staffing level was sufficient.	F 353		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Medicaid residents were provided dental services for 1 of 3 residents (R53) reviewed in the sample with dental issues. Findings include: During an observation on 3/28/16, at 6:44 p.m. R53 was observed to have missing teeth; and on 3/30/16, at 8:02 a.m. R53 was sitting in the dining room eating breakfast. When interviewed on 3/30/13, at 8:15 a.m. R53	F 412	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1) With respect to R53 an oral screen was	5/6/16

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	245320	A. BUILDING _____ B. WING _____	03/31/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 30 expressed concern about partials and teeth needing repair and not understanding why the issues had not been taken care of since the teeth have been a problem for some time. Document review of a form dated 4/30/15, and titled Dental Chart Progress Notes, read, "Treatment recommendations: Filling, extractions, and fabrication of upper full denture. Alternatives to treatments include no extractions and fabrication of new upper partial, however this has a questionable prognosis. Treatment options discussed with patient. Reviewed with patient the examination findings, diagnosis;, treatment options, benefits, risks, limitations, as well as prognosis. Exam every 6 months., Prophy {sic} every 3 months.:" Document review of a form dated 3/28/16, and titled Dental Chart Progress Notes, read, "Moderate generalized chronic periodontitis, Non restorable upper teeth caries requiring restoration." The health unit coordinator (HUC) on 3/30/16, at 2:00 p.m. verified the dental referral form had not been communicated to F53's guardian. The HUC did not know why the guardian was not contacted and could not find any documentation in the medical record to explain why R53 had not received the services recommended by the dentist on 4/30/15.	F 412	completed and dental recommendations presented to the family for making a determination of treatment. 2) All resident records have been audited by Health Information to ensure they have been offered dental care/services within the past 12 months. 3) Health Information staff will receive re-education on the guidelines and process for dental visits. 4) The Director of Nursing and/or Designee will complete two resident chart audits each week for one month and then one resident chart audit per week for two months to assure dental services are offered an obtained as requested. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed during the monthly Quality Meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		5/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	03/31/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 31 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to prevent the spread of infection during	F 441	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	

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

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F 441	Continued From page 32 handwashing for 2 of 5 residents R10, R83); failed to maintain proper aseptic technique during glucometer testing; and failed to implement procedures to prevent the transmission of disease for 2 of 5 residents (R14 & R73) reviewed for tuberculin testing. Findings include: Handwashing: During observation of care for R10 on 3/29/16, at 9:04 a.m. licensed practical nurse (LPN)-A and nursing assistant (NA)-A came to the room to assist R10 to the commode. Both staff donned gloves without first washing their hands. Wearing the gloves, the staff positioned the commode near the resident, put a transfer belt on R10 and placed a pivot board on the floor for the transfer. Before R10 was transferred to the commode an incontinent brief was removed. The incontinent brief was noted to be wet with urine. Staff then removed gloves and reminded each other to wash hands. However, LPN-A was observed to wash hands for 8 seconds and then leave the room. NA-A washed hands for 10 seconds and remained with R10. NA-B came to assist R10 with perineal cleansing following a bowel movement on the commode. NA-B donned gloves without hand washing. After completing cares NA-A washed hands for 9 seconds and left the room. NA-B washed hands for 10 seconds and left the room. During observation of cares for R83 on 3/29/16 at 10:14 a.m. NA-B and LPN-B used alcohol gel to sanitize hands and then don gloves. LPN-B removed gloves after positioning the bed pan under R83. LPN-B then went into the BR and without using soap, rinsed hands for 3 seconds	F 441	as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1) With regards to the identified employees: education has been provided on hand washing and proper aseptic technique during blood glucose testing. R14 and R73 have received a two step TST with negative results. 2) Infection control reports were reviewed and no trends were identified for any particular group assignment. Staff will be observed for proper hand washing and glucose testing technique to prevent the transmission of pathogens and possible infection. All resident records have been reviewed to assure two step TST completion. 3) All nursing staff will receive re-education on the proper technique for hand washing and blood glucose testing. Staff will also receive re-education on the facility's TB Infection Control Plan. Education will be completed by May 6, 2016. 4) The Director of Nursing and/or Designee will audit two staff each week for one month and then one staff each week for two months to assure proper	

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	245320	A. BUILDING _____ B. WING _____	03/31/2016

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

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F 441	Continued From page 33 under running water and then went through the drawer looking for a brief. R83 voided into the bed pan and NA-B emptied the urine into the toilet and set the bedpan on the floor in the bathroom. LPN-B then donned a pair of gloves and applied a barrier cream to R83's perineal area. After removing gloves and again without soap, LPN-A ran water over hands for 3 seconds and dried hands. Then LPN-B took a pair of gloves out of a box sitting on a tray table and assisted with pericare and positioning R83. After turning and positioning, LPN-B removed gloves and again without soap, ran the water over hands for 3 seconds, turned off the water, dried hands and left the room. Document review of the January 2011 policy titled, Standard Precautions, directed staff to wash hands immediately after glove removal and wash hands vigorously for 20 seconds, generating friction on all surfaces including under fingernails. The director of nursing on 3/31/16, at 11:21 a.m. verified staff were to wash hands vigorously for 20 seconds according to the facility policy and procedure. Glucometer: During observation on 3/28/16 at 12:00 p.m., of resident blood glucose monitoring, registered nurse (RN)-A was observed setting the transport container of lancets, cotton balls, antiseptic and bandaids on the back of a public resident use toilet tank, located outside the main dining room. Then, RN-A set the glucometer on the contaminated general use hand washing sink in the same restroom, next to the spigot without a protective barrier. When interviewed, RN-A	F 441	hand washing. Two audits will be completed for per week for one month and then one audit per week for two months on licensed staff to ensure proper aseptic technique during blood glucose testing.. All new admissions will be audited to assure the two step TST is completed per regulation. 5) The data collected from these audits will be presented to the QAPI committee by the Director of Nursing/Designee. The data will be reviewed and discussed during the monthly Quality Meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up.	

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	245320	A. BUILDING _____ B. WING _____	03/31/2016

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F 441	Continued From page 34 verified there should have been a barrier used to protect the supplies from the contaminated areas. TB screening/testing: R14 was admitted on 2/11/16 and R73 was admitted on 3/5/16. A review of the Immunization Record for each resident revealed that tuberculin skin tests had not been given. Document review of the facility policy dated July, 2013, titled, Screening Residents, revealed tuberculin screening/testing should be initiated within 72 hours of admission, and the screening could be either a tuberculin skin test (TST) or a Interferon Gamma Release Assay (IGRA). When interviewed on 3/30/16, at 2:00 p.m. the director of nursing verified residents should have a TST within 72 hours of admission and neither R14 and R73 had been screened/tested.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/30/2016**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Woodlyn Heights Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/21/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/30/2016**

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and angela.kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Woodlyn Heights Healthcare Center is a 2-story building with no basement. The building was built in 1973 and was determined to be of Type II(111) construction. In 2014 a single story addition was added to the East and was determined to be of Type II(111) construction. This facility was surveyed as two separate buildings because of different dates of construction. Building 1 was constructed prior to March 1, 2003. Therefore, it was surveyed in accordance with LSC Chapter 19, and building 2 was surveyed in accordance with LSC Chapter 18. The builfing is fully fire sprinklered. and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 99 beds and had a census of 68 beds at the time of the survey.	K 000		

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	245320	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/30/2016**

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

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on the observation and staff interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3, they did not fit tight in the frame or latch. This deficient practice could affect the safety of approximately 113 of 175 residents and an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 0900 and 1200 on 3/31/2016 observations revealed that the following resident room doors did not positively	K 018	Woodlyn Heights will ensure the facility maintains corridor doors in accordance with NFPA 101 Life Safety Code Standard 1) The facility tour on 3/31/2016 revealed that the following doors did not positively latch, Room# 101, 110, 200, 408 and 600. The noted corridor doors have been repaired appropriately to ensure they latch properly. All doors will be regularly checked for compliance and adjustments/repairs will be made appropriately to ensure all doors positively latch.	4/24/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 018	Continued From page 3 latch: Rm. 600 Rm. 408 Rm. 200 Rm. 101 Rm. 110 The deficient practice was observed by the Maintenance Director (JT).	K 018	2) Corrective action will be completed by April 24, 2016. 3) Maintenance Director/Designee is responsible for corrective action and monitoring.	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 9:00 AM and 12:00 PM on 03/30/2016, based on review of available documentation it was revealed that there was no documentation for the minimum 5 minute cool down period when testing the generator. This deficient practice was verified by the Maintenance Director (JT).	K 144	Woodlyn Heights will ensure the facility maintains the emergency generator in accordance with NFPA 101 Life Safety Code Standards. 1) Maintenance Personnel will continue testing the emergency generator weekly for 30-minutes and then monthly under full load for 30-minutes with an additional 10-minutes for a cool down period. Testing will be documented appropriately. 2) Corrective action will be completed by April 24, 2016. 3) Maintenance Director/Designee is responsible for corrective action and monitoring.	4/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING **02 - 2014 ADDITION** B. WING _____	**03/30/2016**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Woodlyn Heights Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/21/2016

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.

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	245320	A. BUILDING **02 - 2014 ADDITION** B. WING _____	**03/30/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and angela.kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Woodlyn Heights Healthcare Center is a 2-story building with no basement. The building was built in 1973 and was determined to be of Type II(111) construction. In 2014 a single story addition was added to the East and was determined to be of Type II(111) construction. This facility was surveyed as two separate buildings because of different dates of construction. Building 1 was constructed prior to March 1, 2003. Therefore, it was surveyed in accordance with LSC Chapter 19, and building 2 was surveyed in accordance with LSC Chapter 18. The builfing is fully fire sprinklered. and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 99 beds and had a census of 68 beds at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING **02 - 2014 ADDITION** B. WING _____	**03/30/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on the observation and staff interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3, they did not fit tight in the frame or latch. This deficient practice could affect the safety of approximately 113 of 175 residents and an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 0900 and 1200 on 3/31/2016 observations revealed that the following resident room doors did not positively latch: Rm. 600 Rm. 408 Rm. 200 Rm. 101 Rm. 110	K 018	Woodlyn Heights will ensure the facility maintains corridor doors in accordance with NFPA 101 Life Safety Code Standard 1) The facility tour on 3/31/2016 revealed that the following doors did not positively latch, Room# 101, 110, 200, 408 and 600. The noted corridor doors have been repaired appropriately to ensure they latch properly. All doors will be regularly checked for compliance and adjustments/repairs will be made appropriately to ensure all doors positively latch. 2) Corrective action will be completed by April 24, 2016. 3) Maintenance Director/Designee is responsible for corrective action and monitoring.	4/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING **02 - 2014 ADDITION** B. WING _____	**03/30/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 The deficient practice was observed by the Maintenance Director (JT).	K 018		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 9:00 AM and 12:00 PM on 03/30/2016, based on review of available documentation it was revealed that there was no documentation for the minimum 5 minute cool down period when testing the generator. This deficient practice was verified by the Maintenance Director (JT).	K 144	Woodlyn Heights will ensure the facility maintains the emergency generator in accordance with NFPA 101 Life Safety Code Standards. 1) Maintenance Personnel will continue testing the emergency generator weekly for 30-minutes and then monthly under full load for 30-minutes with an additional 10-minutes for a cool down period. Testing will be documented appropriately. 2) Corrective action will be completed by April 24, 2016. 3) Maintenance Director/Designee is responsible for corrective action and monitoring.	4/24/16