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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(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 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	

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

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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.	

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

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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.

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

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F 314	Continued From page 9	F 314		

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

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

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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
F 314	Continued From page 10	F 314		

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.

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

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F 314	Continued From page 11	F 314		

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

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

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F 314	Continued From page 12	F 314		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 14	F 314		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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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WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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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	

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

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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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 19	F 329		

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

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

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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		

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

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F 329	Continued From page 21	F 329		

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

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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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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

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

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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		