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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z35G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00803

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

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

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

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

6. DATE OF SURVEY **04/22/2015** (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 **175** (L18)

13.Total Certified Beds **175** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 04/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/22/2015 (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
06/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/10/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5235

Electronically Delivered: April 22, 2015

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

Dear Mr. Barr:

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

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

Effective April 14, 2015 the above facility is certified for:

175 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 175 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 about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 22, 2015

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

RE: Project Number S5235026

Dear Mr. Barr:

On March 18, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 5, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 22, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 21, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 14, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 5, 2015, effective April 14, 2015 and therefore remedies outlined in our letter to you dated March 18, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne K. Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245235	A. Building B. Wing	4/22/2015

Name of Facility	Street Address, City, State, Zip Code
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/14/2015**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/14/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/14/2015**	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** SR/AK	**Date:** 04/22/2015	**Signature of Surveyor:** 16022	**Date:** 04/22/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/5/2015

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245235	A. Building B. Wing 01 - MAIN BUILDING 01	4/21/2015

Name of Facility	Street Address, City, State, Zip Code
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	03/04/2015	ID Prefix Reg. # NFPA 101 LSC K0062	04/14/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	04/22/2015	12424	04/21/2015
CMS RO				

Followup to Survey Completed on: 3/3/2015

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: Z35G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00803

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(L2) **662675000**

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(L3) **WOODBURY HEALTH CARE CENTER**
(L4) **7012 LAKE ROAD**
(L5) **WOODBURY, MN** (L6) **55125**

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

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

6. DATE OF SURVEY **03/05/2015** (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**
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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 **175** (L18)

13.Total Certified Beds **175** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 03/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 18, 2015

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

RE: Project Number S5235026

Dear Mr. Barr:

On March 5, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
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 14, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 5, 2015 (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 5, 2015 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING _____ B. WING _____	03/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 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 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.	F 280		4/14/15

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

Electronically Signed | 03/26/2015

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
	245235	A. BUILDING _____ B. WING _____	03/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 1 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 3 residents (R48) identified as having a potential for weight loss. Findings include: R48's care plan was reviewed and revealed that on 3/3/15, a revision was made to indicate R48's weights were "trending down" and that on the date of admission (11/25/14) R48 weighed 161.4 pounds; on 1/22/15, R48 weighed 153 pounds; and on 2/15/15, R48 weighed 147.3 pounds. The care plan was also revised on this date to reflect R48 was to receive four ounces of a house nutritional supplement three times a day. However, the care plan was not revised to reflect a 2/23/15, nursing order for R48 to be weighed on Mondays, Wednesdays and Fridays. A nutrition assessment dated 2/25/15, noted: the resident had the potential for altered nutrition; was on a diabetic diet with intakes noted to be 25-100%; was to feed self; had no problems with chewing or swallowing; and was tolerating the current diet. The assessment noted a current weight of 147.2 pounds, "which is down from last assessment weight of 161 pounds." The assessment also noted R48 had been started on 4 ounces of a nutritional supplement three times a day and there was a potential for weight fluctuations due to the use of diuretics. Weight is within the ideal body weight range of 144-176 pounds. However, the assessment did not address the frequency of weights or the 2/23/15, nursing order for three time a week weights.	F 280	F280 The preparation of the following plan of correction for this deficiency does not constitute and should not be interperted 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 forgoing statement, the facility states that: 1. With respect to resident #48; the care plan has been revised to include the current schedule for taking weights. The NAR Assignment sheet reflects all interventions as well as Point of Care documentation in the electronic record. 2. All resident records have been reviewed for weight schedules and the plan of care revised as indicated with revisions to Point of Care documentation and the NAR Assignment sheet. 3. The team responsible for obtaining and reviewing weights will receive education regarding the procedure for making revisions to care plans to maintain accuracy by 4/14/15. 4. The Director of Nursing and/or designee will audit three resident records each week for one month and then two residents each week for two months for monitoring completion of weights as well as accuracy of the resident record. 5. The data collected will be presented to	

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F 280	Continued From page 2 On 3/05/15, at 7:56 a.m. R48's current care plan was reviewed with registered nurse (RN)-A. The care plan lacked a revision related to having R48 weighed on Mondays, Wednesdays and Fridays. The facility's 9/11, policy and procedure titled Care Plan Guidelines indicated anything that was specific to the resident was to be on the care plan.	F 280	the QA and A committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA and A committee will make the recommendation/decision regarding any necessary follow up studies.	
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 document review, observation and interview, the facility failed to follow the care plan for 1 of 1 residents (R101) identified as having the potential for bruising. Findings include: R101's care plan was not followed as there was lack of documentation indicating weekly skin inspections had been conducted or that alterations in R101's skin had been reported to the nurses. R101's care plan revised on 10/24/14, reflected that R101 had a history of refusing cares, and directed staff to lotion skin every day, observe the resident's skin every day with cares and report	F 282	F282 The preparation of the following plan of correction for this deficiency does not constitute and should not be interperted 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 forgoing statement, the facility states that: 1. With respect to resident# 101, the weekly skin inspection was conducted on 3/4/15. The identified nurses who failed to complete or note the skin alteration	4/14/15

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F 282	Continued From page 3 any changes to the nurse. The care plan also directed staff to conduct weekly skin inspections. On 3/03/15, at 12:36 p.m. small nickel and dime sized purple/reddish skin discolorations were noted on the back of each of R101's hands. There was also a purple/red discolored area noted on the left nostril. A review of the electronic health record (eHR) revealed that a nursing entry had been completed on 3/3/15, at 1:23 p.m. This eHR entry addressed the purple discoloration of the left nostril, which measured 1.5 centimeters (cm) by 1 cm. Another eHR nursing entry dated 3/4/15, at 10:37 p.m. indicated the resident had a scheduled shower and there were no skin concerns. Neither eHR nursing entry addressed the condition of R101's hands. On 3/05/15, at 8:49 a.m. the skin discolorations on the back of R101's hands were discussed with registered nurse (RN)-A. RN-A stated this was the first she had heard of skin discolorations on the back of R101's hands. At 8:54 a.m. RN-A looked at R101's hands and verified the skin discoloration had not been documented in the eHR. R101's care plan was also reviewed at this time with RN-A. RN-A was interviewed as to the location of the weekly body audits. RN-A stated the audits were conducted on a resident's bath day and were to be documented on a weekly basis in the eHR. A review of the eHR revealed that weekly skin audits of R101's skin were not always completed. The eHR revealed a body audit was conducted on 3/4/15, however, the previous body audit had been conducted 1/21/15. There was no	F 282	received individual education. 2. All residents records have been reviewed to assure completion of weekly skin audits. Instruction to complete the weekly skin inspection is documented weekly on the resident treatment record and signed off by licensed nurse. All skin alterations noted during care and/or weekly skin inspections are then documented in the resident record in a progress note with a description of the skin alteration. 3. All nursing staff will receive education regarding the completion of weekly skin inspections for identification and assessment of new or existing skin alterations. Education will be completed by 4/14/15. 4. The Director of Nursing and/or designee will audit three residents each week for one month and then two residents each week for two months to assure the plan of care for the individual resident is being revised and followed in regards to completion and documentation of the completed weekly skin inspections. 5. The data collected will be presented to the QA and A committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA and A committee will make the decision/recommendation regarding any necessary follow up studies.	

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F 282	Continued From page 4 documentation found indicating a weekly body audit had been conducted for the month of 2/15. Further review of the eHR revealed that body audits were conducted on 10/15/14, but the next body audit was not conducted until 12/13/14.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that interventions to minimize non-pressure related skin conditions were implemented for 1 of 1 residents (R101) identified as having the potential for bruising. Findings include: On 3/03/15, at 12:36 p.m. small nickel and dime sized purple/reddish skin discolorations were noted on the back of each of R101's hands. There was also a purple/red discolored area noted on the left nostril. A review of the electronic health record (eHR) revealed that a nursing entry was done on 3/3/15, at 1:23 p.m. addressed the purple discoloration of the left nostril, which measured 1.5 centimeters (cm) by 1 cm. Another eHR nursing entry dated 3/4/15, at 10:37 p.m.	F 309	F309 The preparation of the following plan of correction for this deficiency does not constitute and should not be interperted 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 forgoing statement, the facility states that: 1. With respect to resident# 101, the weekly skin inspection was conducted on 3/4/15. The identified nurses who failed to complete or note the skin alteration received individual education. 2. All residents records have been	4/14/15

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F 309	Continued From page 5 indicated the resident had a scheduled shower and there were no skin concerns. Neither eHR nursing entry addressed the condition of R101's hands. On 3/05/15, at 8:49 a.m. the skin discolorations on the back of R101's hands were discussed with registered nurse (RN)-A. RN-A stated this was the first she had heard of skin discoloration on the back of R101's hands. At 8:54 a.m. RN-A looked at R101's hands and verified the skin discoloration had not been documented in the eHR. R101's care plan revised on 10/24/14, reflected that R101 had a history of refusing cares, that their skin was to be lotioned every day, that staff were to observe the resident's skin every day with cares and report any changes to the nurse. The care plan also indicated weekly skin inspections were to be conducted. R101's care plan was also reviewed at this time with RN-A. RN-A was interviewed as to the location of the weekly body audits. RN-A stated the audits were conducted on a resident's bath day and were to be documented on a weekly basis in the eHR. The facility's 8/11 policy titled Weekly Skin Inspection Implementation Guidelines, indicated a weekly skin inspection was to be done on a weekly basis by a nurse in conjunction with the resident's weekly bath to identify and treat any skin concerns. Weekly skin checks were to be signed out in the medication administration record (MAR) by the licensed staff; if an abnormality was found then documentation was to be completed by the licensed staff in the medical record.	F 309	reviewed to assure completion of weekly skin audits. Instruction to complete the weekly skin inspection is documented weekly on the resident treatment record and signed off by licensed nurse. All skin alterations noted during care and/or weekly skin inspections are then documented in the resident record in a progress note with a description of the skin alteration. 3. All nursing staff will receive education regarding the completion of weekly skin inspections for identification and assessment of new or existing skin alterations. Education will be completed by 4/14/15. 4. The Director of Nursing and/or designee will audit three residents each week for one month and then two residents each week for two months to assure the plan of care for the individual resident is being revised and followed in regards to completion and documentation of the completed weekly skin inspections. 5. The data collected will be presented to the QA and A committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA and A committee will make the decision/recommendation regarding any necessary follow up studies.	

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F 309	Continued From page 6 A review of the eHR revealed weekly skin audits of R101's skin were not always completed. The eHR revealed a body audit was conducted on 3/4/15, but the previous body audit was conducted 1/21/15. There was no documentation found indicating a weekly body audit had been conducted for the month of 2/15. Further review of the eHR revealed that body audits were conducted on 10/15/14, but the next body audit was not conducted until 12/13/14. A review of the MAR revealed licensed staff had not documented the weekly skin inspections as having been completed for the weeks of 1/17, 1/24, and 2/7/15.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R30), requiring assistance with nail care, was not provided assist until the scheduled bath day. Findings include: On 3/03/15, at 4:55 p.m. R30 was observed with brown colored debris beneath both thumbnails, as well as some long and jagged fingernails on both hands. On 3/04/15, at 9:01 a.m. and 11:26 a.m. there was no change in the condition of	F 311	F311 The preparation of the following plan of correction for this deficiency does not constitute and should not be interperted 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 forgoing statement, the facility states	4/14/15

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F 311	Continued From page 7 R30's fingernails. On 3/05/15, at 7:04 a.m. there was still no change in the condition of R30's fingernails. A significant change minimum data set completed on 12/22/14, revealed R30 required extensive assistance with washing and drying of face and hands, however, the care plan last revised on 8/18/14, and reviewed on 12/30/14, revealed R30 required assistance of staff for all ADL's, and staff were to complete all grooming. The care plan also indicated R30 was able to wash and dry hands and face after given a prepared cloth. On 3/05/15, at 7:06 a.m. nursing assistant (NA)-A stated R30 was due for a bath that day and NA-A would do the bath after breakfast. NA-A started the morning cares at at 7:59 a.m., and at 8:27 a.m. NA-A was observed to wash and dry R30's face and hands. Nail care was not completed at this time. During interview, on 3/05/15, at 11:55 a.m. RN-A was informed of R30's jagged nails and of the debris under the thumbnails that had been observed over the past two days. RN-A verified the condition of the fingernails and stated R48 was bathed on Thursdays and only on a weekly basis. When asked what the facility policy was for trimming fingernails, RN-A stated "at a minimum weekly on bath day, when the nails are soft." Although R30's fingernails were scheduled to be trimmed/cleaned on 3/5/15, R30 was observed to have brown colored debris beneath both thumbnails, as well as some long and jagged fingernails on both hands, for 2 days. The facility's 8/11 policy titled Weekly Skin	F 311	that: 1. Nail care was provided for resident #30 on 3/5/15. The NAR's providing cares to resident #30 received education for completing nail care in between scheduled bath days if the nails are dirty or rough. 2. All resident nails on the identified unit have been examined for proper care and maintenance. Care has been provided when indicated and individual education as appropriate. 3. The Guidelines for Standards of Resident Care has been reviewed and revised. All nursing staff will receive education regarding the procedure for care and maintenance of finger and toe nails. The education will be completed by 4/14/15. 4. The Director of Nursing and/or designee will audit three residents cares each week for one month and then two residents each week for two months to assure nail care is being provided. 5. The data collected will be presented to the QA and A committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA and A committee will make the decision/recommendation regarding any necessary follow up studies.	

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F 311	Continued From page 8 Implementation Guidelines, revealed nail care was to be done weekly on bath days, and diabetic nail care was to be done by licensed staff on a weekly basis. A review of the care plan last revised on 8/18/14 and reviewed and completed on 12/20/14, revealed R30 did not have a diagnosis of diabetes.	F 311		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R48) identified with the potential for weight loss, was adequately monitored so as to minimize the potential for further weight loss. Findings include: On 3/4/15, at 11:47 a.m. R48 was observed sitting in a wheelchair, at a table in the third floor west dining room. At 11:51 a.m. R48 received meal and without prompts began to eat. At 12:25 p.m. R48 pushed away from the table and began	F 325	F325 The preparation of the following plan of correction for this deficiency does not constitute and should not be interperted 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 forgoing statement, the facility states that:	4/14/15

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F 325	Continued From page 9 to wheel self out of the dining room. As R48 was leaving the dining room R48 was approached by a nursing assistant who looked at R48's plate and was heard to ask the R48 if finished with the meal. The nursing assistant offered theR48 some dessert. R48 reported to the nursing assistant not being hungry and did not want anything else. R48 had consumed all of the juice, water and coffee provided and only a few bites of the sweet potato, ground ham and pineapple slice. A review of the electronic health record (eHR) revealed R48, was admitted to the facility on 11/25/14, weighing 161.4 pounds and the most current weight was recorded on 2/27/15, as 146.1 pounds; a total weight loss of 15.3 pounds since admission. A review of the physician orders in the eHR revealed on 2/23/15, a nursing order that directed staff to have the resident weighed three times a week. The review also revealed on 2/12/15, the physician had ordered a 4 ounce nutritional supplement three times a day, and on 12/11/14, a once a day multivitamin had been ordered. On 3/5/15, at 7:50 a.m. licensed practical nurse (LPN)-A was interviewed regarding how often R48 was to be weighed and LPN-A thought the resident was weighed weekly and weights were in the eHR. When the MAR was reviewed with LPN-A and registered nurse (RN)-A and the three time a week weight frequency pointed out, LPN-A appeared surprised and stated "Oh." Both LPN-A and RN-A verified the MAR indicated R48 was to be weighed three times a week and no weights were recorded on the 3/15 MAR. LPN-A again stated the weights might be located in the eHR.	F 325	1. With respect to resident #48; the care plan has been revised to include the current schedule for taking weights. The NAR Assignment sheet reflects all interventions as well as Point of Care documentation in the electronic record. 2. All resident records have been reviewed for weight schedules and the plan of care revised as indicated with revisions to Point of Care documentation and the NAR Assignment sheet. 3. The team responsible for obtaining and reviewing weights will receive education regarding the procedure for making revisions to care plans to maintain accuracy by 4/14/15. 4. The Director of Nursing and/or designee will audit three resident records each week for one month and then two residents each week for two months for monitoring completion of weights as well as accuracy of the resident record. 5. The data collected will be presented to the QA and A committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA and A committee will make the recommendation/decsision regarding any necessary follow up studies.	

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F 325	Continued From page 10 A review of the eHR revealed there were no weights recorded for 2/23, 2/25, 3/2 and 3/4/15. The last recorded weight for R48 was 146.1 pounds on 2/27/15. On 3/5/15, at 8:00 a.m. the surveyor requested of RN-A a more current weight for R48. RN-A reported at approximately 8:10 a.m. that R48 was weighed and a weight of 146.6 had been obtained.	F 325		
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 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.	F 329		4/14/15

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F 329	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to follow up with pharmacy recommendations with the attending physician for 2 of 5 residents (R48, R194) in the sample who were reviewed for unnecessary medications. Finding include: A review of the consulting pharmacist monthly drug regimen worksheet revealed on 1/6 and 3/3/15, the consulting pharmacist had noted an irregularity, and information had been sent to the attending physician. A review of the paper medical record did not indicate what the pharmacist recommendations were and on 3/5/15, at 7:45 a.m. registered nurse (RN)-A was asked what the pharmacist recommendations had been. RN-A provided a copy of the 3/3/15, recommendation and stated the 1/6/15, recommendation was no longer available and explained that it was the same as the 3/3/15, recommendation. RN-A also stated at this time neither the 1/6 or 3/3/15, pharmacist recommendations had been addressed by either the attending physician or nurse practitioner. The consulting pharmacist's recommendation dated 3/3/15, (and which according to the interview with RN-A, was the same as the 1/6/15 recommendation) revealed the pharmacist recommended discontinuation of the physician ordered ibuprofen 200 milligrams (mg) every day and 200 mg when necessary for pain (prn) in the afternoon and evening, because of	F 329	F329 The preparation of the following plan of correction for this deficiency does not constitute and should not be interperted 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 forgoing statement, the facility states that: 1. Pharmacy recommendations for resident's #194 and #48 have been addressed with the resident's primary physician and orders received/transcribed as indicated. 2. All pharmacy recommendations have been reviewed for the past three months to assure follow up with the resident's provider as indicated. 3. The guideline for pharmacy recommendations has been developed. Clinical Managers will receive education regarding the consulting pharmacist recommendations and follow up required by 4/14/15. 4. The Director of Nursing and/or designee will audit three resident records each week for one month and then two residents each week for two months to assure appropraite follow up is completed per Pharmacy recommendation. 5. The data collected will be presented to	

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	245235	A. BUILDING _____ B. WING _____	03/05/2015

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F 329	Continued From page 12 gastrointestinal and renal risks associated with nonsteroidal anti-inflammatory drugs (NSAID) use. The report indicated the rationale for the recommendation was R48 was also on aspirin 325 mg every day and was having ongoing issues with nausea and vomiting, as well as a comorbitity of hypertension. The pharmacist recommended the use of Tylenol 650 mg twice a day and 650 mg twice a day for pain instead of the ibuprofen. A review of physician orders in the eHR indicated R48 continued to receive aspirin 325 mg daily, as well as ibuprofen 200 mg daily. There was no indication the physician had addressed the consulting pharmacist recommendations regarding the ibuprofen and Tylenol. RN-A stated on 3/5/15, at 7:45 a.m. the consulting pharmacist emailed all the recommendations to the nurse manager (NM) and then the NM would get the recommendations to the appropriate physician. For R48 the recommendations were placed in a folder on the unit for nurse practitioner to review at the time of their next on site visit. RN-A stated the consulting pharmacists recommendations had been faxed to R48's attending physician and the fax had not been followed up on by the physician's office. When asked about facility policy/procedure/protocol for ensuring the physician and/or nurse practitioner addressed the recommendations in a timely manner, RN-A stated they were not aware of any written protocol on what the facility was to do in the event the physician and/or nurse practitioner failed to address pharmacy recommendations.	F 329	the QA and A committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA and A committee will make the recommendation/decision regarding any necessary follow up studies.	

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A review of physician and/or nurse practitioner visit documentation revealed the nurse practitioner had seen R48 on 1/4/15, and the physician had seen R48 on 2/6/15, but the pharmacist recommendations had not been addressed.

On 3/5/15, at 1:10 p.m. the director of nurses (DON) was interviewed regarding how facility staff were to follow up to ensure pharmacist recommendations were acted upon. The DON stated NM's were to make copies of the recommendation and also fax the recommendations to the physician's office. The recommendations were put in a folder located at the front desk and R48's nurse practitioner had requested their own folder to be located on the third floor. The DON stated they expected the pharmacist recommendations to be addressed within a month and nurse practitioners were in the building on an almost weekly basis. The DON stated there was no specific policy regarding the time frame in which the physician and/or nurse practitioner was to address a pharmacist recommendation.

R194's diagnoses included dementia with behavioral disturbances, anxiety state and depressive disorder obtained from the physician orders signed and dated 1/14/15, by the nurse practitioner. In addition the physican orders dated 1/14/15, and the Medication Administration Record (MAR) dated March 2015, revealed R194 had orders for Celexa (antidepressant) 20 mg (milligrams) daily, Trazodone (antidepressant) 75 mg at bedtime, and Depakote 250 mg at 8:00 a.m. and Depakote 125 mg daily at 12 noon.

R194's consulting pharmacist monthly

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medication regimen review sheet indicated on 1/7/15, the consulting pharmacist had made recommendations, and information had not been sent to the attending nurse practitioner or physician to give advice.

A review of the Consultant Pharmacist Communication to Physician dated 1/7/15 revealed, "[R194] has been having several falls recently and is on several psychotropic medications that increase falls risk. His wandering that induces falls seems to be between 1600-2200 PM generally speaking with some outliers. His trazodone 75 mg is given at 2200, Depakote at 800, and 1200 and Celexa at 800. In attempt to try and reduce these falls, one idea to try is changing dose times to: Trazodone 25 mg every [Q] 1600, and 50 mg QHS (splitting the evening dose) Depakote 250 mg Q 800, and 125 mg Q 1600 (delaying the evening dose) Celexa 20 mg QAM - same I feel this would give him better coverage during the times when his behaviors are higher, as well as increasing the non-pharmacological interventions used with him in the PMs. Hope this might help, Thanks!" During further document review it was revealed although R194 had a physician visit on 1/8/15, pharmacist recommendations had not been addressed until 3/4/15 at 2:43 p.m. when surveyor brought it to the facility attention.

On 3/4/15 at 2:49 p.m. the consulting pharmacist (CP) stated, "The expectation was the facility was to act upon in a reasonable time frame about a month prior to next visit." In addition, CP stated, she had talked to nurse manager/registered nurse (RN)-A regarding the recommendation. On 3/5/2015 at 9:55 a.m. RN-A stated, "we have approached NP about the pharmacy

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F 329	Continued From page 15 recommendation but especially after [R194] falls but NP was reluctant to change the medications and NP stated [R194] medications were not changed while at hospital, why change it here. In addition, RN-A mentioned, "I had spoken with NP on the telephone and in person when she was in the building, and she said will address it after assessing [R194] and this was on 1/8/2015". On 3/5/15 at 11:05 a.m. the director of nursing (DON) explained that the expectation is when the nurse managers receive pharmacist recommendations, nurse managers should update the physician or nurse practitioner for response and if no response in a timely manner (within a month) the nurse manager should contact DON or medical director so action can be taken. DON indicated the medical director would be contacted for further advice. On 3/5/2015 at 11:14 a.m. the nurse practitioner stated, "I have a folder at the front desk and during my visits there were never any pharmacy recommendations for [R194] and I could not make a recommendation because there was none in my folder. I like pharmacy recommendations and I address them at any facility I go. I did not know about this one and it was not communicated to me, therefore it was not addressed." On 3/5/15 at 1:10 p.m. DON stated that there was not a policy and procedure related to pharmacy recommendations.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		4/14/15

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F 431	Continued From page 16 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired medications were removed from the medication carts for 3 of 3 residents (R10, R160, and R321,) whose medications had expired.	F 431	F431 The preparation of the following plan of correction for this deficiency does not constitute and should not be interperted as an admission nor an agreement by the	

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F 431	Continued From page 17 Findings include: R10's Advair inhaler, with an opened date of 12/30/14, was stored on one of the Transitional Care Unit's (TCU) medication carts on 3/2/15, at 6:40 p.m. The resident's Medication Administration Record (MAR) for March 2015, included a current physician's order for Advair Diskus Aerosol Powder 1 puff inhale orally two times a day. The record showed the medication had been administered four times in March and twenty eight days in February. Licensed Practical Nurse (LPN)-C stated she thought the medication was good for 30 days and verified it was expired, and should not be used. R160's Lantus insulin with an expiration date of 2/12/15, was stored for use on one of the second floor medication carts on 3/2/15, at 6:53 p.m. The resident's MAR included a current physician's order for Lantus Solution Inject 15 units subcutaneous one time a day related to DIAB w/o comp (Diabetes with out complications), and the record showed the medication had been administered to R160 sixteen times after the medication expiration date. LPN-B verified the Lantus was expired, and should not have been used. R321 Novolog insulin dated with an open on date of 2/1/15, was stored for use on one of the TCU's medication carts on 3/2/15, at 6:42 p.m. The resident's MAR included a current physician's order for Novolog 4 units with lunch. Hold if BS (blood sugar) is >150. RN-B indicated the insulin is good for 28 days, and verified the insulin was expired.	F 431	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 forgoing statement, the facility states that: 1. With respect to resident's #10, #160, and #321, the identified medications were removed from the medication storage and disposed of properly. 2. All medication storage areas have been inspected for proper compliance with handling, storage, and dating of opened medications. All medications not in compliance have been disposed of according to facility protocol. 3. Processes have been developed for periodic inspection of the medication storage areas for cleanliness, proper storage and disposal. All licesed staff and trained medication aides will receive education regarding medication expiration and storage guidelines by 4/14/15. 4. The Director of Nursing and/or designee will audit three medication storage areas each week for one month and then two medication storage areas each week for two months to assure proper storage, dating and disposal of expired medications. 5. The data collected will be presented to the QA and A committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA and A committee will make the recommendation/decision regarding any	

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F 431	Continued From page 18 Interview with the Director of Nursing (DON) on 3/5/15, at 1:20 p.m., indicated the facility had a procedure to prevent expired medications from being used, and there should not be any expired medications on the medication carts. Review of the facility's procedure, on 3/5/15, labeled "Medication Expiration Procedures", dated July 2008, indicated the following: 1. See attached list of medications that have specific expiration dates, 2. When one of these medications are ordered, a sticker with Date open/Expired/ Initials are placed on the MAR below the order for the medication. 3. When the medication is opened the nurse will document the date opened and the date of expiration along with his/her initials. At the date of expiration the medication will be discontinued and re-written as a new order to show when a new supply has been started. 4. 5 days prior to the expiration date the nurse will indicate on the med sheet to reorder the medication. This will allow time for the new supply to be in the facility on the date of expiration. Review of the undated "Medication Storage and Expiration Guidelines" from Merwin Long Term Care Pharmacy on 3/5/15, indicated Advair Diskus expired 30 days after opening, and insulin vials expire 30 days after opening.	F 431	necessary follow up studies.	

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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Woodbury 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: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, 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 | 03/26/2015

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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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. Woodbury Healthcare Center is a 4-story building with no basement. The building was constructed at 2 different times. The original 3 story building was constructed in 1979 and was determined to be of Type II(222) construction. In 1986, a fourth floor addition was constructed that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 175 beds and had a census of 165 at the time of the survey. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is within 3 feet and adequate to	K 000		

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K 000	Continued From page 2 provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. A K-067 was written in previous years. The facility has corrected this deficiency. A correction plan was submitted and accepted by MDH on 12/4/2013. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 This deficient practice could affect all residents, guests and staff within the smoke compartments Findings include: On facility tour between 09:00 AM and 02:00 PM	K 029	K029 1. Ground floor laundry room door fixed to automatically close and latch completely 2. Storage room 006 door equipped with automatic self closing device. 3. Completion date 3/4/15 4. Maintenance Director responsible for completion.	3/4/15

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K 029	Continued From page 3 on 03/03/2015, it was observed that: 1) The ground floor Laundry Storage Room door did not automatically close and latch when tested. This deficiency was verified by the Maintenance Director (TK), 2) The door to the ground floor mattress and furniture Storage Room 006, was not equipped with an automatic self closing device.	K 029		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review, obsrevation and interview the automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all occupants of the building if the system were to fail under fire conditions. Findings include: On facility tour between 09:00 AM and 02:00 PM on 03/03/2015, it was revealed during review of available fire sprinkler records and observation that there was no documentation of the fire sprinkler gauages having been calibrated or replaced in the last 5 years. This deficiency was varified by Maintenance Director (TK).	K 062	K062 1. Fire sprinkler gauges to be replaced. 2. Proposed completion date 4/13/15. 3. Maintenance Director responsible for completion.	4/14/15