DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 23, 2026

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

RE: CCN: 245235
Cycle Start Date: May 26, 2026

Dear Administrator:

On June 17, 2026, we informed you of imposed enforcement remedies.

On July 9, 2026, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

F656 - Develop/Implement Comprehensive Care Plan

F684 - Quality of Care

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 2, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 2, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 2, 2026.

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

As we notified you in our letter of June 17, 2026, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 2, 2026.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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).

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor, Rapid Response
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 26, 2026 (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.

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.

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 12, 2026

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

RE: CCN: 245235

Cycle Start Date: May 26, 2026

Dear Administrator:

On June 17, 2026, we notified you a remedy was imposed. On August 11, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 10, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 2, 2026 be discontinued as of August 10, 2026. (42 CFR 488.417 (b))

In our letter of June 17, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 2, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

8/12/2026

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

RE: 232B0E-H3

CCN: 245235

HFID: 00803

Dear Administrator:

On August 5, 2026, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $300.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on August 5, 2026 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $300.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $255.20, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Minnesota Department of Health in the amount of $555.20 within 15 days of the receipt of this notice.

Please send a copy of this letter and the check to:

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64975
Financial Management
St. Paul MN 55164-0975

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

cc: Holly Zahler, Health Program Rep Senior
Shellae Dietrich, Health Program Manager
Joanne Simon, Health Program Rep Principal
Kami Fiske-Downing, Health Program Rep Senior
HRD Deposit Team

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2026

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

RE: CCN: 245235
Cycle Start Date: May 26, 2026

Dear Administrator:

On May 26, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 2, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 2, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 2, 2026.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager

or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 2, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, WOODBURY HEALTH CARE CENTER will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 2, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor, Rapid Response
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 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.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 26, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2026

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

Re: State Nursing Home Licensing Orders
Event ID: 232B0E-H1

Dear Administrator:

The above facility survey was completed on May 26, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Nikki Harvey, Regional Operations Supervisor, Rapid Response
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

******REVISED LETTER - REPLACES LETTER POSTED ON 7/23/26.***

DISREGARD PREVIOUS LETTER.***

Electronically delivered

July 27, 2026

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

RE: CCN: 245235
Cycle Start Date: May 26, 2026

Dear Administrator:

On June 17, 2026, we informed you of imposed enforcement remedies.

On July 9, 2026, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

F656 - Develop/Implement Comprehensive Care Plan

F684 - Quality of Care

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 2, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 2, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 2, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new

admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of June 17, 2026, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 2, 2026.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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).

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor, Rapid Response
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health

4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 26, 2026 (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.

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.

APPEAL RIGHTS

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

after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD , WOODBURY, Minnesota, 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
F0000	INITIAL COMMENTS On 5/20/26, 5/21/26, 5/22/26, and 5/26/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52352117C (3007404) with deficiencies issued at F684, F690, and F825. As a result of the investigation deficiencies were cited at F550, F656, F686, and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		06/17/2026
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by:	F0684	Plan of Correction: F0684 – Quality of Care: Treatment/Services to Prevent/Heal Pressure Ulcers and manage change in condition Deficiency Statement The alleged deficiencies for residents R1, R2, and R4 have been corrected as of June 18, 2026. Immediate interventions included: Comprehensive reassessment of R2, and R4 by the	07/03/2026

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 reverse for further 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.

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

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F0684 SS = G	Continued from page 1 Based on interview and document review the facility failed to assess and monitor a change in condition for 3 of 4 residents (R1, R2, R4) reviewed for wound care. The lack of assessment and monitoring for R1 resulted in harm for R1 when R1 appeared to be sleeping in bed but instead had a change in responsiveness and mentation, was not assessed timely for the change, and was hospitalized. The lack of thorough assessment and monitoring for R2 resulted in delay in treatment for wounds related to moisture associated skin damage (MASD). Wound care staff identified wounds on 4/28/26, but were not evaluated until 5/11/26. The wounds were open and R2 reported pain associated with the wounds. The lack of assessment and monitoring for R4 resulted in harm when R4 was noted to have a change in condition, staff did not perform ongoing assessments and monitoring, the provider was not notified of the changing and deteriorating condition, and R4 was found unresponsive in bed two days after becoming ill and was subsequently transferred to the hospital. Findings include: R1 R1's admission Minimum Data Set (MDS) dated 3/15/26 indicated intact cognition, dependence upon staff for assistance with activities of daily living (ADLs), no behaviors including refusals of care, and diagnoses that included kidney insufficiency, urinary tract infection (UTI) in the previous 30 days, liver disease, and hypertension. R1's provider progress note dated 4/29/26 indicated the provider reviewed the resident with the facility nursing staff and nurse manager to watch R1 carefully as she may need further hospitalization for diuresis (pass increased amount of urine), and to watch vital signs (VS). R1's provider orders dated 4/29/26 indicated Lasix (diuretic – medication used to promote the production of urine by the kidneys used to flush out	F0684	Continued from page 1 Director of Nursing (DON) or designee. R1 has passed away in the hospital. No current changes in condition noted and wound in improving status. Review of wound care treatment and plan of care for R2 and R4, Reviewed and implemented condition monitoring for affected residents. Immediate education provided to all nursing staff on timely assessment, documentation, and provider notification for changes in resident condition including new skin condition process. The Director of Nursing (DON) was responsible for implementing these corrections. Identification of Other Residents at Risk Residents who have wounds or high risk Braden scores, are at risk for skin breakdown, or have experienced a change in condition have the potential to be affected by the alleged deficient practice. The DON/designee completed audits of all current residents with wounds/risk for wounds or recent changes in condition as of June 23, 2026 to ensure no other residents were affected. Measures and Systemic Changes to Prevent Recurrence Staff Training: All licensed nursing staff to receive in-service training on: Timely and thorough assessment/observation of changes in resident condition including abnormal vital signs Documentation requirements for wound care and changes in condition. Immediate provider notification protocols and escalation protocol for any resident exhibiting a change in mentation, responsiveness, or wound	07/03/2026

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F0684 SS = G	Continued from page 2 excess salt and water) 40 milligrams (mg) one time a day at 8:00 a.m., and 20 mg one time a day at 1:00 p.m., for edema. The provider orders lacked indication staff were to monitor R1's carefully for indication she may need further hospitalization for diuresis per the provider's progress note on 4/29/26. R1's care plan lacked mention R1 was taking a diuretic or needed careful monitoring for the need for further diuresis at the hospital. R1's progress notes indicated the following: 5/2/26 at 10:01 p.m., vital signs (VS) were checked at 10:22 p.m.: blood pressure (BP) 101/55, pulse (P) 79, respirations (R) 18, temperature (T), 96.9 Fahrenheit (F), oxygen saturation (O2 sats) 99% on room air (RA). Resident was alert and oriented and coherent, with clear speech. 5/2/26 at 10:20 p.m., vital signs stable, pedal pulse on left ankle not palpable. 5/2/26 at 10:43 p.m., R1 was taken to the hospital. R1's After Visit Summary from the hospital dated 5/2/26 indicated R1 had a diagnosis of cellulitis (bacterial infection of the skin and underlying tissue) and was started on an antibiotic. R1's diagnosis list dated 5/3/26 indicated a diagnosis of cellulitis of the left lower limb. R1's progress notes after the hospitalization indicated the following: 5/3/26 at 6:40 a.m., returned from hospital with new orders and diagnosis. 5/3/26 at 10:50 a.m., VS were assessed at 7:48 a.m. and were BP 100/58, P 94, R 16, T 97.4 F, O2 sats 96% on RA, resident followed commands, was alert and oriented. 5/3/26 at 6:09 p.m., VS BP 118/60, P 84, R 18, T 96.9 F, O2 sats 98% on RA, alert and oriented, coherent with clear speech. 5/4/26 at 2:26 p.m., VS T 97.6 F assessed at 12:49	F0684	Continued from page 2 status. Training was started on June 24, 2026. On-call and PRN staff will receive this training prior to their next scheduled shift. This education will be completed by the compliance date noted below. Process Changes: Implementation of a "Change in Condition" assessment tool, e-interact change in condition form effective June 22, 2026. Daily monitoring by director of nursing or designee of weekly skin checks to ensure timely implementation of plan of care and daily monitoring of vitals exception reports (abnormal vitals). Procedures "Assessments and Monitoring of Resident Condition" and "Wound Care Management" were reviewed as of June 18, 2026 Monitoring and Quality Assurance Woodbury Health Care Center will monitor performance to ensure sustained compliance. The DON or designee will audit: All new changes in condition for assessment and skin check documentation for implementation of new skin condition process, Three times weekly until 4 weeks of consecutive compliance of 100% is reached Audit results will be presented to the QAPI committee monthly, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. Compliance Date	07/03/2026

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F0684 SS = G	Continued from page 3 p.m., P 85 and R 18 assessed at 2:28 p.m. Resident was alert and oriented, and able to follow commands. The progress note lacked indication BP and O2 sats were assessed. 5/4/26 at 9:42 p.m., VS T 97.7 F assessed at 9:09 p.m., P 87 and R 17 assessed at 9:43 p.m. Resident was alert and oriented and able to follow commands. The progress note lacked indication BP and O2 sats were assessed. 5/5/26 at 12:29 p.m., VS BP 92/53, P 114, R 18, T 97.0 F. Resident complained of hip and left calf pain at 12:00 p.m.; Tylenol was given. The progress note lacked indication O2 sats were assessed and lacked further mention of the low BP and elevated P, lacked later reassessment of the VS, and lacked indication the VS were reported to the provider. 5/5/26 at 3:15 p.m., VS P 85, R18, T 97.7 F. Resident is alert and oriented, followed commands. The progress note lacked indication BP or O2 sats were assessed. 5/6/26 at 3:29 p.m., VS BP 45/26, P 66, R 22, T 97.0 F, O2 sats 98% on RA. Resident had very low BP and was alert knew her first and last name but did not know where she was and was lethargic. 5/6/26 at 4:16 p.m., VS 50/26, pulse 66, R 22, T 97.0 F. Resident follows commands, has not been eating any of her food, especially this shift. 5/6/26 at 4:27 p.m., when caregivers offered to do cares, R1's family would tell staff to come back because R1 was sleeping. At 2:30 p.m. during medication pass, the trained medication aide (TMA) came to pass meds, and was told to come back later. The licensed practical nurse (LPN)-A went to check on R1 and BP was noted to be very low; the provider was updated and gave orders to send R1 to the emergency room (ER). The progress note lacked indication staff assessed R1 even though it was unusual for her to sleep during the day. R1's death certificate dated 5/7/26 at 12:27 p.m., indicated R1 died of multiorgan failure due to septic and hemorrhagic shock, acute renal (kidney) failure, and acute respiratory failure. During an interview on 5/19/26 at 11:33 a.m., social worker (SW)-A stated when R1 was intubated shortly after she arrived at the hospital on 5/6/26, and family reported R1 was not acting like herself and	F0684	Continued from page 3 Woodbury Healthcare Center will be in substantial compliance by July 3rd, 2026. Responsible Party: Director of Nursing (DON) Woodbury Senior Living 6/18/2026	07/03/2026

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F0684 SS = G	Continued from page 4 didn't want to talk to her husband that day which was not normal for R1. The SW-A stated R1's family reported being very concerned about the care R1 received at the facility. During an interview on 5/21/26 at 2:46 p.m. the family member (FM)-A stated the day after R1 died, she visited the facility to discuss with a registered nurse (RN) how R1 was fine one day, and on lift support the next day. The FM-A stated FM-B and FM-C had seen R1 the morning R1 was transferred to the hospital. R1 complained of a headache the morning of 5/6/26, and was sleeping a lot, which was unusual for her; her baseline was lively and talkative. The FM-A stated FM-C visited R1 in the morning on 5/6/26, and FM-B visited around 10:00 a.m., and R1 slept through both visits. FM-A stated it was after lunchtime when staff checked on R1, but FM-C asked staff to let R1 sleep. A nurse came in later, and assessed R1, and then rushed to send R1 to the hospital. During an interview on 5/21/26 at 3:27 p.m., the FM-C stated on 5/6/26 R1 was sleeping a lot which was not normal. A nurse came to R1's room at approximately 10:00 a.m., physical therapy and occupational therapy staff came and left when I sent them away. The FM-C stated she looked for a wound care nurse in the facility because the wounds on R1's legs were weeping. A nursing assistant (NA) entered R1's room around 2:00 p.m., and wanted to give R1 some medication, but because R1 had complained about that NA previously, the FM-C asked them to leave. The NA sent a nurse back in to give the medication but didn't give the medication and instead called emergency medical services to send R1 to the hospital. She had just been in the hospital with sepsis the Thursday or Friday after Easter. The day before she went to the hospital on 5/6/26, R1 kept saying she wanted her mom and didn't seem real energized but was usually more alert than she was that week. She seemed to be declining all week. During an interview on 5/21/26 at 4:04 p.m., the nurse practitioner (NP)-A stated she was not informed R1 had an UTI, and a urine test had not been ordered for R1 after her hospitalization in April. R1 was very ill and had been declining. Staff had to monitor R1 closely because she was immobile, at risk for infection, and had so many contributing co-morbidities.	F0684		07/03/2026

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F0684 SS = G	Continued from page 5 During an interview on 5/22/26 at 10:14 a.m., the FM-C stated when R1 went to the hospital on 5/6/26, hospital staff told the FM-C R1 was very sick may not make it through the night. They put a tube down her throat, and when they pulled that out, R1 died about 30 minutes later. The FM-C stated he visited R1 on 5/6/26 at the facility, and stated staff looked at R1 in her room, and walked away, but did not assess her. During an interview on 5/22/26 at 2:54 p.m., the RN-A stated after R1 returned from the hospital in April 2026, the care provided included checking R1's blood pressure, wounds care for the wounds on R1's legs, and catheter care. During an interview on 5/26/26 at 11:39 a.m., the licensed practical nurse (LPN)-A stated she took R1's VS on 5/6/26 and was very concerned. R1 was conscious and speaking but didn't know where she was. She was sleepy all day and hadn't felt well. The DON didn't want me to send R1 to the hospital again, but we did send her in later in the day. During a subsequent interview on 5/26/26 at 12:29 p.m., the NP-A stated any resident required assessment when they were sick and the provider should be updated any time a resident had a change in condition. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated R1 was assessed on 5/6/26 right before she was sent to the hospital but did not appear to have any assessment on 5/6/26 that day prior to that because the family wanted her to sleep. If the nurse was concerned, she should have awakened her to assess her. When nurses do a set of VS, they should include a blood pressure, pulse, respirations, temperature, and oxygen saturations, and usually pain. Staff would not know R1's condition if they didn't assess her. During an interview on 5/26/26 at 2:46 p.m., the medical director (MD)-A stated R1 was very frail and compromised and should have been assessing for signs of infection and fever. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated the expectation was	F0684		07/03/2026

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F0684 SS = G	Continued from page 6 if R1 or her family refused care, the expectation was for nursing staff to educate the resident or the family about the need for care, and then document in a progress note that care was refused and education was provided about the risks and benefits of refusing the care. If R1's BP was low, staff should recheck the BP, and if it is still low, report it to the provider. R2 R2's annual MDS dated 5/11/26, indicated severe cognitive impairment, R2 was always incontinent of bowel and bladder, was at risk for developing pressure ulcers (PU), and had diagnoses that included dementia and arthritis. R2's grievance log entry dated 3/31/26, indicated R2's was supposed to be added to wound rounds but had not been. R2's grievance log entry dated 5/11/26, indicated R2's FM-D was concerned about R2's wound. R2's care plan indicated the following: 5/14/22, revised 6/22/22, indicated R2 wore incontinence products daily, apply barrier cream/protective ointment after each incontinent episode. 5/14/22, revised 4/21/25, reposition every 2-3 hours and as needed 10/28/25, check and change for incontinence every 2-3 hours 5/14/22, revised 5/20/26, indicated R2 had potential impairment to skin integrity related to incontinence, immobility, and medication use with current MASD with treatment with an ointment. Interventions were added 5/18/26 including "see the Skin/Wound tab in the medical record for current skin measurements and interventions," treatment as ordered and notify provider if the skin alteration was worsening or shows signs and symptoms of infection or no improvement in fourteen days. R2's progress notes indicated the following:	F0684		07/03/2026

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F0684 SS = G	Continued from page 7 4/1/26 at 11:27 a.m., new skin issue, MASD on the intergluteal cleft (the deep vertical groove that runs between the buttocks) 3.99 centimeters (cm) x 4.25 cm, 100% granulation tissue, no drainage, cleaned with generic wound cleaner, treated with Calmoseptine Ointment used to prevent and soothe skin irritations), to be treated daily and as needed (PRN). The progress notes lacked mention the provider was notified. 4/7/26 at 9:36 a.m., MASD on the intergluteal cleft was healed. 4/7/26 at 3:38 p.m., MASD, in-house acquired, on intergluteal cleft that had not been evaluated by a provider. The note lacked mention of treatment, clinical treatment suggestions, or notification to the provider. 4/14/26 at 3:20 p.m., MASD in the intergluteal cleft, in-house acquired with a clinical suggestion to apply barrier cream to the skin, that had not been evaluated by a provider. The progress note lacked mention of notification to the provider. 4/17/26 at 6:10 p.m., Calmoseptine External Ointment 0.44020.6% was ordered, apply to buttocks two times a day for wound care to buttocks twice a day (BID) and PRN 4/28/26 at 3:13 p.m., MASD, in-house acquired on the left gluteal fold that had not been evaluated by a provider; barrier cream was applied. The progress note lacked mention of notification to the provider. 5/5/26 at 12:26 p.m., MASD, in-house acquired on the intergluteal cleft that had not been evaluated by a provider. The progress note lacked mention of treatment, clinical suggestions, or notification to the provider. 5/5/26 at 10:01 p.m., a Braden Evaluation (assessment tool used to predict risk of developing pressure ulcers) was completed with a score of 12, which indicated a high risk of developing PU. 5/9/26 at 11:35 p.m., resident's daughter indicated R2 might have a wound on her bottom she was not informed about. The LPN-B performed an assessment that revealed on-going MASD and a Stage 1 PU(skin is not broken but is red and discolored or may show hardness or temperature change compared to the skin around it) about 1 cm to 2 cm on R2's coccyx. The LPN-B informed the nurse on-coming nurse for the subsequent shift and advised that nurse to inform the resident provider on	F0684		07/03/2026

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F0684 SS = G	Continued from page 8 Monday, 5/11/26, so they can possibly prescribe a topical ointment for the resident coccyx. The progress note lacked evidence the LPN-B notified the provider of the PU. 5/11/26 at 2:01 p.m., MASD on the gluteal cleft that had been evaluated by a provider, noted as an in-house acquired new wound that measured 1.36 cm in width (W) x 1.45 cm in depth (D), with 100% granulation tissue (new pink connective tissue that fills the base of a wound), with orders to clean the wound with generic wound cleaner and cover it with Calmoseptine Ointment daily and PRN. R2's Skin Issues/ Skin Checks notes indicated the following: 4/1/26 at 11:27 a.m., Skin Issues: new issue, intergluteal cleft, MASD, 3.99 cm x 4.34 cm, 100% granulation tissue, no drainage. The care planning and clinical suggestions sections were not completed. 4/7/26 at 9:36 a.m., Skin Issue: in-house acquired MASD on intergluteal cleft, resolved. 4/7/26 at 3:38 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft, with no education provided, no provider/family notifications or clinical suggestions noted. 4/14/26 at 3:20 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft, no education provided, no provider/family notifications noted. Clinical suggestion indicated apply barrier cream to skin. 4/22/26 at 9:59 a.m., Skin Issues: in-house acquired MASD on intergluteal cleft, resolved. 4/28/26 at 3:13 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft, no provider/family notifications or clinical suggestions noted. 5/5/26 at 12:26 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft, no provider/family notifications or clinical suggestions noted. 5/11/26 at 2:01 p.m., Skin Issues: evaluated, in-house acquired MASD on intergluteal cleft, new wound, 1.36 cm x 1.45 cm, 100% granulation tissue, "none" exudated noted, but has exudate noted to be serosanguinous (mixture of serous – clear pale	F0684		07/03/2026

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F0684 SS = G	Continued from page 9 watery fluid and sanguinous fluid-contains fresh blood or has a blood-like appearance), with a pink wound bed, and minimal dressing saturation, treated with Calmoseptine ointment daily and PRN, with no care plan or wound interventions noted. The skin assessments lacked indication a skin check was performed on R2 the week of 4/21/26. R2's provider orders indicated the following: 2/3/26 Calmoseptine Ointment .44-20.6% ointment, apply to buttock topically two times a day (BID) for wound cares to buttock and PRN During an interview on 5/20/26 at 3:56 p.m., the FM-D stated R2 had a wound on her bottom for the 3rd or 4th time, because facility staff didn't change R2's incontinence brief frequency enough and R2 lays on her backside in bed for hours in a row. The FM-D stated for the last six months, she requested R2 be put to bed after 9:00 p.m., and to be gotten up on the morning before 10:00 a.m. The FM-D stated she visits R2 almost daily, and leaves the facility around 7:00 p.m. or 7:30 p.m. nightly, and the video camera footage in the room revealed staff putting R2 to bed around 7:45 p.m., nightly after the FM-D leaves for the day. The video camera footage revealed staff gets R2 up in the morning between 11:00 a.m. and 11:30 a.m., and then don't change R2's incontinence brief again util they put her to bed at night. The FM-D further stated she has talked to staff about it daily for about three weeks because the routine had not changed, but not R2 at least gets checked and changed at the end of first shift and is them up in her chair again until bedtime. The FM-D stated she discovered R2 has a wound on her bottom when she saw a soiled incontinence wipe and undergarment in the garbage that had blood on them on 5/2/26. The FM-A stated she asked the facility DON to have a wound nurse assess the wound, and was told it happened, but when she reviewed camera footage, discovered no wound rounds occurred for R2. The FM-A then spoke to the DON, stated she had been lied to about the wound care team seeing R2, and asked again for the wound care team to see R2. The DON assessed the wound, ordered a product from the pharmacy called butt goop, and told the FM-D the wound should have been assessed long before it was. Now, as seen by the FM-D on video footage, the wound care team visits R2 weekly on Wednesdays. The FM-A stated she just wants the wound treated, was concerned about infection, and the wound looked really raw	F0684		07/03/2026

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F0684 SS = G	Continued from page 10 and red the last tine she saw it, approximately two weeks prior to the interview. Additionally, the FM-D stated she had video footage of staff wiping R2's wounds and R2 hollered out in pain during the care. The FM-D stated, if the wounds had been found before they were open, they might not be so painful to clean. During an interview on 5/26 26 at 10:09 a.m., the LPN-B stated R2 had ongoing MASD, and it was possible the treatment was not working because it kept returning. The treatment was to apply a barrier cream and reposition R2 every two to three hours. The LPN-B stated weekly skin checks were performed each week during the resident's bath time, and if it was not completed weekly, skin deterioration could be missed that wasn't identified previously. During an interview on 5/26/26 at 12:29 p.m., the NP-A stated if R2 did not get the wound checks and assessments as ordered, new wounds could be missed, or the wounds could get worse. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated staff told the wound team about wounds on R2's bottom, but during assessment, the wound team did not locate the wounds. Twice, staff sent pictures to the wound team, and the wound team did not find the wounds. After R2's family got upset with the DON, the wound team looked a third time, and moved skin folds around more, and discovered two wounds on R2's perineum (region of the body located between the thighs between the anus and vaginal opening). The RN-B stated the wound did not likely recur but were likely present each time. The RN-B stated she didn't think repositioning in a wheelchair would make a difference, but instead it was the sitting on the area that was likely causing the issue. The RN-B stated she was unsure if that education was provided to the family and did not find any documentation indicating education to the family about not sitting on the wounds had occurred. The RN-B acknowledged R2 did not have a skin check the week of 4/21/26 and stated the facility could miss new wounds when the assessments were not done weekly. During an interview on 5/26/26 at 2:32 p.m., the nursing assistant (NA)-A stated she thought R2 had pain with the wounds on her bottom and sometimes	F0684		07/03/2026

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F0684 SS = G	Continued from page 11 hollered out during checks and changes for incontinence. During an interview on 5/26/26 at 3:31 p.m., the DON stated R2 had previous MASD wounds, and then recently staff found them again. Ensuring skin checks are completed timely, education about refusals of care, and keeping R2 as dry as possible were keys to ensure MASD didn't occur. The DON acknowledged R2 did not have a skin check on 4/21/26 but should have and acknowledged skin checks were utilized to discover new skin issues, and skin issues forms were utilized to assess current skin issues, and stated "It could have potentially made a difference if that skin check had been done. I wish we had noticed the wounds sooner." R4 R4's Medicare 5-Day MDS dated 4/23/26 indicated R4 had intact cognition, was dependent upon staff for applying footwear, had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure ulcer, diabetes, and diabetic foot ulcers. R4's care plan indicated the following: 5/4/23 difficulty sleeping 6/13/23 type II Diabetes 6/13/23 altered cardiac status related to congestive heart failure (chronic progressive condition in which the heart cannot pump blood efficiently enough to meet the body's needs) and hypertension (high blood pressure) 7/24/23 peripheral vascular disease (slow progressive circulatory disorder characterized by the narrowing, blockage, or spasms of blood vessels, most commonly reducing blood flow to the arms, legs, and feet 5/12/25 impaired vision 6/30/25 incontinence of bowel 12/12/25 encephalopathy (broad term for any disease, damage, or malfunction that affects the brain's function, with an altered mental state that	F0684		07/03/2026

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F0684 SS = G	Continued from page 12 may include confusion, memory loss, or personality changes) 12/18/25 kidney failure related to Type II diabetes 4/2/26 actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema (chronic condition of build-up of fluid from the lymphatic system (network of tissues, organs, and vessels that maintain fluid balance, absorbs dietary fats, and defends the body against infections and circulates lymph fluid (colorless, watery fluid) throughout the body) in the body's soft tissues, usually in the arms or legs often started with swelling in the hands or feet). Interventions included protecting bony areas with pillows and supportive devices initiated 1/6/22, and pressure relief ankle foot orthosis (PRAFO, used to stabilize the ankle, prevent foot drop, and eliminate pressure on the heels) boots on at all times, initiated 5/4/23. R4's orders included the following: 4/17/26 Novolog (a short-acting insulin given before meals, often given in combination with a long-acting insulin) Flex Pen 100 units/milliliter (unit/ml), inject 20 units subcutaneously (subq) before meals 4/18/26 Novolog Flex Pen 100 unit/ml sliding scale, inject subq before meals: if blood glucose (BG): 150-199 give 3 units 200-249 give 6 units 250-299 give 9 units 300-349 give 12 units 250-399 give 15 units 400+ give 18 units and call physician 4/17/26 oxycodone hydrochloride (HCl - narcotic pain medication administered for moderate to severe pain) 5 milligrams (mg), give 5 mg by mouth as needed for pain one time daily in the morning, in the evening, and PRN for pain one time daily. 4/17/26 Sildenafil citrate 20 mg, give 20 mg three times daily related to pulmonary hypertension (high	F0684		07/03/2026

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F0684 SS = G	Continued from page 13 blood pressure in the arteries that carry blood from the heart to the lungs) 5/11/26 UA/UC for cloudy urine and chills R4's diagnoses list dated 5/20/26, included diagnosis of sepsis dated 5/19/26. R4's care timeline provided by email by the facility after the survey exit as supplemental documentation on 5/28/26 at 5:55 p.m., indicated the timeline was developed using nursing documentation and review of video footage from the facility, revealed the following: 5/12/26 at 7:38 a.m., not feeling well, provider ordered UA/UC, observed vomiting, resident declined going to the Emergency Department. The timeline lacked indication a nursing assessment was completed, or VS were taken. 5/12/26 at 8:00 a.m., NA entered the room, daily weight taken. The timeline lacked indication VS were taken, what care was provided, or the condition of the resident. 5/12/26 at 8:53 a.m., a nurse entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident. 5/12/26 at 9:02 a.m., a nurse entered the room to administer medication. The timeline lacked indication a nursing assessment was performed, or VS were taken. 5/12/26 at 10:27 a.m., a nurse and trainee were observed entering the room briefly to monitor. The timeline lacked mention of what monitoring occurred, nor what was observed. 5/12/26 at 11:34 a.m., a nurse entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident. 5/12/26 at 11:41 a.m., a NA entered the room. The timeline lacked indication VS were taken, what care was provided, or the condition of the resident. 5/12/26 at 12:21 p.m., a NA brought lunch to the room. The timeline lacked information about the condition of the resident. 5/12/26 at 1:04 p.m., the timeline indicated, "Oxygen tank" with no further reference.	F0684		07/03/2026

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F0684 SS = G	Continued from page 14 5/12/26 at 2:10 p.m., a NA entered the room. The timeline lacked indication VS were taken, what care was provided, or the condition of the resident. 5/12/26 at 3:33 p.m., a NA entered the room. The timeline lacked indication VS were taken, what care was provided, or the condition of the resident. 5/12/26 at 2:24 p.m. a nurse and trainee entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident. 5/12/26 at 4:20 p.m., the NP was notified the UA was back. No further assessment details were included. 5/12/26 at 5:30 p.m., a nurse entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident. 5/12/26 at 6:08 p.m., a NA entered the room. The timeline lacked indication VS were taken, what care was provided, or the condition of the resident. 5/12/26 at 6:22 p.m., a nurse took R2's temperature. The timeline lacked indication a nursing assessment was performed, additional VS were taken, or the condition of the resident. 5/12/26 at 7:49 p.m., a NA entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident. 5/12/26 at 8:15 p.m., a NA entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident. 5/12/26 at 8:44 p.m., a nurse entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident. 5/12/26 at 10:21 p.m., a nurse documented lethargy all shift, and indicated her note she was frequently monitoring from 2:30 p.m., to 10:30 p.m. The timeline lacked indication a nursing assessment was performed (other that indicating lethargy), VS were taken, or the condition of the resident. 5/12/26 at 10:47 p.m. a nurse entered the room. The timeline lacked indication a nursing assessment was	F0684		07/03/2026

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F0684 SS = G	Continued from page 15 performed, VS were taken, or the condition of the resident. 5/13/26 at 12:53 a.m., assessed by nurse and sent to ER. The timeline included 18 opportunities for staff to take VS, 11 opportunities for a nurse to perform an assessment including taking VS and reporting on the condition of the resident. The timeline lacked mention R4 started feeling ill on 5/11/26, lacked mention of any VS other than one temperature, and lacked an update on R4's condition to the provider other than to report the UA was back. R4's progress notes indicated: 5/11/26 at 2:01 p.m., oxycodone Hcl 5 mg was administered for back pain 5/11/26 at 3:55 p.m., urine was cloudy this shift and temperature was 99.3 [Fahrenheit (F)]. The nurse practitioner was notified and an order was given for UA/UC (urinalysis – a urine test and urine culture – to test for bacteria). Report given to p.m. shift nurse. 5/11/26 at 4:59 p.m., urine specimen collected this evening. Lab has been called for collection. 5/11/26 at 5:11 p.m., refused scheduled Novolog injection but allowed the Novolog sliding scale injection, and did not want to eat dinner. 5/12/26 at 6:40 a.m., indicated R2 was not feeling well, a UA/UC were collected, resident was weak and had vomited, R2's VS were P-83, O2 sats 91 %, on 5 liters (L) O2 per his baseline, with a temperature of 101.1. The nurse offered to send R4 to the ER, but R4 declined to go. R4 requested PRN Tylenol 1000 mg which he took. The VS lacked assessment of BP and respirations. The nurse reported R4's condition to on-coming staff. The note lacked mention of an update to the resident's provider or family. 5/12/26 at 7:46 a.m. resident's current condition inhibited any leg treatments. The progress note lacked mention of a nursing assessment or VS taken. 5/12/26 at 11:15 a.m., resident refused to eat. The progress note did not indicate why, a nursing assessment, or VS.	F0684		07/03/2026

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F0684 SS = G	Continued from page 16 5/12/26 at 2:14 p.m., Tylenol 1000 mg given for pain. The resident had a temperature of 100.5 F. The progress note lacked mention of the location of the pain, other VS, or additional nursing assessments. 5/12/26 at 2:20 p.m., oxycodone HCl 5 mg administered for back pain 5/12/26 at 3:27 p.m., Tylenol effective was rated as ineffective with pain rated as 5/10. R4 also had oxycodone HCl 5 mg at 2:20 p.m. The progress note lacked an update to the provider about unmanaged pain or that an extra oxycodone HCl was required or administered. 5/12/26 at 3:28 p.m., refused Novolog 20 units insulin. The note lacked indication that the provider was notified of insulin refusals on 5/11/26 and 5/12/26 or education about the risks and benefits of refusing the medication. 5/12/26 at 4:20 p.m., the provider was notified of resident change in condition. 5/12/26 at 9:49 p.m., resident refused Sildenafil Citrate 20 mg, resident if very lethargic. The progress note lacked mention of notification to the provider the resident refused the medication or education about the risks and benefits of refusing the medication. 5/12/26 at 10:16 p.m., resident lethargic all shift, waiting for culture results from UA, brother was present and will be back 5/13/26, resident refused some of his meds, did not eat or drink and needed help holding a cup. The progress notes lacked VS, a nursing assessment, or indication the provider was aware of R4's current condition. 5/13/26 at 1:15 a.m., R4 was found unresponsive in his bed, O2 sats 77% on 5 L O2 at 12:50 a.m. Provider notified at 12:53 a.m., and order received to send R4 to the ER for further evaluation and treatment. The progress notes lacked an assessment of VS other than O2 sats. 5/13/26 at 3:30 a.m., R4 admitted to hospital, noted with temperature of 103.3F. The progress notes lack evidence of nursing assessments including full vital signs, pain assessment, changes in cognition and speech, lung sounds, changes in mobility or elimination, and lacked evidence of education provided to either the resident or the resident's family member about the risks and benefits of medication refusals, delay in	F0684		07/03/2026

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F0684 SS = G	Continued from page 17 care and hospitalization, or palliative care options. R4's vital signs records lacked indication a blood pressure was assessed after 5/1/26 at 3:47 p.m., a pulse was assessed between 5/1/26 at 3:47 p.m., and 5/12/26 at 9:55 p.m., or a temperature was taken between 5/1/26 at 3:47 p.m., and 5/12/26 at 6:28 p.m., other than the two mentioned in the progress notes. During an interview on 5/20/26 at 11:58 a.m., R4 stated he had returned from the hospital the day prior for an infection in his blood. During an interview on 5/22/26 at 9:57 a.m., the FM-E stated R4 had many hospitalizations, seemingly related to his catheter and UTIs. The FM-E stated he was concerned about R4's recent hospitalization because it seemed like a delay in care, with a fever of almost 101 degrees F, and history of hospitalizations for UIT, the provider would start an antibiotic more quickly. R4 started showing signs of not feeling well on 5/11/26 but did not get an antibiotic until he got to the hospital on 5/13/26. The average person sees a doctor at a clinic and goes home with medication, but that does not happen for him. He doesn't get the labs or the medication quickly. Staff waits to tell the doctor he is sick, waits for lab orders, and waits for the lab results, and by then needs hospitalization. Staff usually notified FM-E when R4 refused to go to the hospital but did not this time. There were times when FM-E could reason with R4 to accept care or to go to the hospital. This time staff waited too long and R4 was in respiratory distress. I can usually determine when to send him to the hospital better than a doctor who has not laid eyes on him During an interview on 5/22/26 at 2:05 p.m., the RN-E stated on 5/12/26 at 4:20 p.m., the NP was in the facility and RN-E notified the NP of R4's condition. He was having a fever around 99 degrees F, and the NP said we should wait for his urine culture to come back. The RN-E stated she told the NP R4 might be sick and the evening shift nurse needed to watch R4. The RN-E stated she had taken R4's temperature and given PRN Tylenol, but didn't document those interventions in the progress notes, but should have. Further, the RN-E stated she should have done a full set of VS, listened to lung sounds and breathing, and completed a full head to toe assessment and stated the on-coming nurse	F0684		07/03/2026

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F0684 SS = G	Continued from page 18 should have done the same because R4 typically got sick quickly. During an interview on 5/26/26 at 10:36 a.m., the LPN-D stated R4 was recently hospitalized for UTI, seemed to get UTIs where he would become shaky, unresponsive, and septic. R4 didn't typically refuse medications unless he was very ill and not responding. R4's brother was present the night of 5/12/26 and was adamant about waiting for the culture results, but the LPN-D acknowledged she had not discussed the risks and benefits of delaying hospitalization with R4's brother but should have. The LPN-D stated she took R4's temperature one time during her shift, but had not reassessed the temperature or performed other VS, but should have. During an interview on 5/26/26 at 10:39 a.m., the LPN-C stated R4 had recently been hospital, and was not feeling well on 5/12/26 around 6:30 a.m., R4 had a fever and had vomited. The LPN-C stated she did not complete a full set of VS, and just reported R4's condition to the on-coming nurse. Further, the LPN-C stated it was the end of her shift, and she had not updated the provider or R4's family about R4's condition because she had another resident to take care of, and there was no time to make the calls. The LPN-C stated she was supposed to put a progress note in the chart when a resident refused to go to the hospital and then notify the nurse manager (NM) and call the on-call provider and put a progress note in the chart about that too. The LPN-C stated she had notified the NM by entering a progress note about R4's condition, because the NM would have known from morning report. The LPN-C acknowledged she did not put in a progress note that she advised R4 to go to the hospital and didn't put in a late entry note about it because she didn't work for several days after that shift. During an interview on 5/26/26 at 12:29 p.m., the NP- A stated with a change in condition, nursing staff should perform assessment that included more frequent VS, any resident needed to be assessed when they were sick, or they could get worse. Updating the provider should be done with any change in condition and continue as the resident's condition progressed. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated when a refused care,	F0684		07/03/2026

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F0684 SS = G	Continued from page 19 staff should educate the resident and document about it, and with a change in condition, nursing should perform full nursing assessments and keep the provider updated. During an interview on 5/26/26 at 2:46 p.m., the medical director (MD)-A stated when he reviewed R4's medical record, R4 was treated for UTI and sepsis, has a chronic catheter and catheter-associated UTIs, and was not aware R4 had been ill. The staff collect data and collect a UA / UC. When UTI was suspected, staff would monitor symptoms, and providers would treat the condition when the culture results came back. In between, staff were expected to call the provider with updates and have a triage line to report to. They monitor symptoms and report the results. They look for delirium or gross hematuria (blood in the urine), monitor VS more often, and look for pain and signs and symptoms of pyelonephritis (kidney infection) and get directions from the provider. There should have been more monitoring when they suspected infection. Documentation was the key, and they staff have to communicate with the provider. During an interview on 5/26/26 at 3:31 p.m., the DON stated R4 was hospitalized frequently and had a UA on 5/11/26 because he was not feeling well. The DON acknowledged she did not see VS documented for R4, and would have expected full sets of vital signs, increased monitoring, and education to the patient and family member about R4's condition. Further, the DON stated the provider should have been notified of every decline in R4. The brother was aware of R4's condition on the evening of 5/12/26 because he was with R4. Nursing staff should have educated R4's brother and it was in R4's best interest to go to the hospital and should have documented that education. The Skin Management Program dated 11/2017, indicated the program was utilized to promote the prevention of alterations in skin integrity, promote healing of skin alteration, and to prevent further loss of skin integrity. All residents will be assessed for skin integrity alterations or changes in skin conditions upon preadmission screening, admission, daily within the plan of care, and weekly with a bath. The Change in Condition policy dated 5/24, indicated staff would implement a change in condition evaluation when a resident had a change	F0684		07/03/2026

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F0684 SS = G	Continued from page 20 in condition that was sudden onset, a marked change in relation to the resident's usual signs. Non-immediate and routine notifications were to be made the same day, during normal business hours or the next day after hours. The Change in Condition Evaluation was used for all changes that required physician/NP notification unless there were other specific physician/ NP orders. For a change in condition, the nurse will reference the Condition-Data Collection and Documentation Guidelines and/or the Care Path within the Change in Condition Evaluation in Point Click Care.	F0684		07/03/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F0550	Plan of Correction: F0550 – Dignity and Respect of Individuality • The alleged deficiencies for resident(s) R4 have been corrected as of 06/18/2026. Upon identification of the deficiency: R4's call light was answered promptly, protective heel boots were donned, and a blanket was being utilized per preference to ensure his comfort and dignity. Immediate education was provided to the staff involved regarding the importance of timely response to call lights, honoring resident requests, and maintaining resident dignity at all times including providing comfort measures when requested or applicable. The Director of Nursing (DON)/designee was responsible for implementing these corrections. • Residents who require assistance with call lights, protective devices, or personal comfort measures have the potential to be affected by the alleged deficient practice. The DON has completed audits of all residents requiring similar assistance as of 06/22/2026 to ensure no other residents were affected. This included review of call light response times, resident protective devices, and observation of resident comfort and dignity during care including needs being met at the end of visit. • The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur:	07/03/2026

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F0550 SS = D	Continued from page 21 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review the facility failed to promote dignity for 1 of 4 residents (R4) when his call light was not answered timely, staff did not honor a request to don R4's protective heel boots, and did not provide a blanket to cover his body. Findings include: R4's Medicare 5-Day Minimum Data Set (MDS) dated 4/23/26 indicated R4 had intact cognition, was dependent upon staff for activities of daily living (ADLs) including applying footwear, had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure ulcer, diabetes, and diabetic foot ulcers. R4's care plan indicated the following: 11/15/23- dependent on staff to put on/take off shoes 4/2/26- indicated R4 had potential and actual skin impairment, admitted to the facility on 3/23/26 with an unstageable right heel venous ulcer (sores that typically occur on the legs due to poor blood circulation), left medial malleolus (bony prominence on the inner side of ankle) diabetic ulcer, a left plantar (foot) ulcer, and right medial calf (inner side of the lower leg). 4/2/26- actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema (chronic condition of build-up of fluid from the lymphatic system (network of tissues, organs, and vessels that maintain fluid balance, absorbs dietary fats, and defends the body against infections and circulates lymph fluid (colorless, watery fluid) throughout the body) in the body's soft tissues, usually in the arms or legs often started with swelling in the hands or feet). Interventions included protecting bony areas with pillows and supportive devices initiated 1/6/22, and pressure relief ankle foot orthosis (PRAFO, used	F0550	Continued from page 21 All nursing and CNA staff received re-education starting on 06/24/2026 regarding: Audited call lights for previous 3 days starting on 6/23 to identify any trends with wait times (within facility policy standards). No trends identified. Honoring resident requests for protective devices and comfort items Promoting and maintaining resident dignity at all times with needs met by end of visit. The "Resident Dignity and Call Light Response" policy have been reviewed as of 06/21/2026. Education will be provided for all nursing staff, CNAs, and PRN staff regarding the policies and processes. This education will begin 6/24/2026 On-call or PRN staff not working during this period will receive training prior to their next scheduled shift. • Woodbury Health Care Center will monitor performance to ensure sustained compliance. The DON or designee will audit call light response times daily and review top 3 longest occurances. The goal is to imporve overall average top 3 longest occurances response time by 15 percent. Documentation of resident protective devices such as heel protectors or other extremity protectors, and observation of resident comfort/dignity during care, three times weekly until 4 weeks of consecutive 100% compliance has been met. Audit results will be presented to the QAPI committee, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. • Woodbury Senior Living will be in substantial compliance by 07/3/2026	07/03/2026

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F0550 SS = D	Continued from page 22 to stabilize the ankle, prevent foot drop, and eliminate pressure on the heels) boots on at all time initiated 5/4/23. During continuous observation on 5/22/26, starting at 1:13 p.m., R4 was lying in bed covered in a white sheet, his protective boots were sitting in his recliner out of reach. R4's call light was activated. At 1:51 p.m., the nursing assistant (NA)-D responded to R4's call light. R4 told the NA-D he would like his boots on and asked the NA-D to tell the nurse he was waiting for his wound care. The NA-D responded to R4, "Right now?" R4 told the NA-D his boots were supposed to have been on since after his morning bath. The NA-D shut R4's door, and when it was opened again at 1:54 p.m., R4's protective boots were on his feet. R4 was covered with a sheet. During an interview on 5/22/26 at 1:13 p.m., R4 stated he had been trying to get a blanket after his morning bath but was told the facility did not have a blanket to give him. R4 was covered in a white sheet but wanted a blanket because he had visitors coming and didn't want just a see-through sheet, so his visitors didn't see his wounds. It was R4's birthday, and he just wanted to be covered properly for his guests. R4 stated he had asked his NA about what was in his recliner several times and was told only a pillow was in the recliner. The NA did not tell R4 his boots were also in the recliner. Because R4 didn't have feeling in his lower extremities, and had poor vision, R4 stated that he could not see what was in the chair and did not know his boots were not on his feet. During an interview on 5/22/26 at 1:54 p.m., the nursing assistant (NA)-C stated he was not R4's NA that day but just came to answer R4's call light. The NA-C stated staff was supposed to answer call lights within five minutes, NA-C stated R4 would likely be upset about having to wait to get assistance from staff and would be embarrassed if he was not able to cover his body with a blanket as requested. During an interview on 5/22/26 at 2:05 p.m., the registered nurse (RN)-C stated all staff were responsible for answering call lights. RN-C hadn't seen R4's call light because she was not able to see the banner which displayed the activated call lights. Further, the RN-C stated R4 would not feel	F0550		07/03/2026

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F0550 SS = D	Continued from page 23 important to staff if he had to wait all morning to get a blanket or his protective boots and further stated the NA should have looked for a blanket for R4 on another floor. During an interview on 5/22/26 at 2:25 p.m., the NA-D stated he was R4's assigned NA for the shift, and stated R4's boots were supposed to go on in the morning. The NA-D stated he informed NA-C he was going on break and NA-C should have answered R4's call light. The NA-D acknowledged R4 wanted his protective boots, a blanket, and staff didn't answer R4's call light timely. The NA-D stated R4 would be sad, disappointed, and not well cared for when his needs weren't met. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated waiting 38 minutes for a call light response was too long, and staff were expected to answer call lights as quickly as possible, "Thirty-eight minutes sitting there waiting feels like a lifetime." Further, the DON stated R4 would feel terrible waiting for his protective boots, and when residents asked for help, staff was expected to help meet their needs. The Promoting/Maintaining Dignity policy dated 4/1/26 indicated it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance guidelines included: During interactions with residents, staff must report, document and act upon information regarding resident preferences. Respond to requests for assistance in a timely manner. The Call Lights Accessibility and Timely Response policy dated 4/2025 indicated that all staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.	F0550		07/03/2026

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F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656	Plan of Correction: F0656 – Comprehensive Care Plans • The alleged deficiencies for resident(s) R1, R2, and R4 have been corrected as of 06/20/2026. For R1, resident has since passed away in the hospital. For R2, nursing staff that were not following the care plan received immediate education and follow up on 5/25/2026 prior to next assigned shift worked. R4, Direct care staff received immediate education on the importance of following care plans as written on 6/22/2026 The Director of Nursing (DON)/designee was responsible for implementing these corrections. • Residents who require comprehensive care plans and/or have care planned interventions have the potential to be affected by the alleged deficient practice. The DON completed audits of all current residents' care plans and care plan implementation documentation of residents who require 2 assist for adl's, those with compression intervention, and those with skin protective devices as of 06/22/2026 to ensure no other residents were affected. • The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: All licensed nursing staff members received in-service training on the development, review, and implementation of comprehensive care plans starting on 06/24/2026. Education will be provided for all licensed nurses and certified nursing assistants regarding the	07/03/2026

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F0656 SS = D	Continued from page 25 Based on interviews and document review, the facility failed to develop a comprehensive care plan for 1 of 4 resident (R1) reviewed for compressive care plan. Additionally, based on interviews, observations, and document review, the facility failed to implement care planned interventions for 2 of 4 residents (R2, R4) reviewed for care plan implementation. Findings include: R1 R1’s admission Minimum Data Set (MDS) dated 3/15/26, indicated intact cognition, impairment in both upper extremities, dependence upon staff for lower extremity dressing. R1's diagnoses included kidney disease, hypertension, and liver disease. R1’s orders dated 4/23/26, indicated wrap bilateral lower extremities with Kerlix and then ACE wraps, one time a day for edema, on in the morning, off at bedtime. R1’s care plan dated 3/27/26, indicated R1 wore ACE wraps, on in the morning, and off at bedtime. The care plan lacked the indication for use and lacked mention of lymphedema (swelling caused by accumulation of protein-rich fluid in the body's tissues) treatment with compression and pumps. During an interview on 5/21/26 at 2:46 p.m., the family member (FM)-A stated R1 was admitted to the facility for lymphedema care. During an interview on 5/22/26 at 11:22 a.m., the admissions coordinator (AC)-A stated R1 had orders for lymphedema care upon admission, which used to be managed by the therapy department, but was now managed by the nursing department. During an interview on 5/22/26 at 2:54 p.m., the registered nurse (RN)-A stated the therapy department provided lymphedema care for R1. Nursing placed bandages and ACE wraps on R1’s legs for lymphedema, and R1’s husband put lymphedema pumps on R1’s legs. The RN-A stated she was unsure if R1 had a care plan for	F0656	Continued from page 25 processes for care plan implementation and following the care plan with a focus on skin protective interventions and edema management. This education begin on 6/24/2026. On-call or PRN staff not working during this period will receive training prior to their next scheduled shift. • Woodbury Health Care Center will monitor performance to ensure sustained compliance. The DON or designee will audit 1 quarterly care plan review and implementation documentation 3 times weekly until 4 weeks consecutive compliance is met. Audit results will be presented to the QAPI committee monthly, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. • Woodbury Senior Living will be in substantial compliance by 07/3/2026.	07/03/2026

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F0656 SS = D	Continued from page 26 lymphedema care, but all care interventions required a care plan. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated R1 did not have a care plan for lymphedema care because nursing staff was not trained for lymphedema care, only for the bandages and ACE wraps. RN-B acknowledged ACE wraps were mentioned on R1's care plan but the care plan did not indicate why. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated R1 was admitted to the facility with orders for lymphedema wraps for her legs, which the facility therapy department provided but at some point (the DON didn't know the date), the therapy department deferred R1's lymphedema care to the nursing staff. R1's family member was managing R1's compression wraps and pumps. The DON acknowledged R1's care plan did not include focus areas or interventions for staff or R1's family to manage R1's lymphedema care but should have. This was important so staff would know how to manage the lymphedema care. R2 R2's annual MDS dated 5/11/26, indicated severe cognitive impairment. R2 was always incontinent of bowel and bladder, was at risk for developing pressure ulcers (PU), and had diagnoses that included dementia and arthritis. R2's care plan dated 4/21/25, indicated two staff were required to dress R2's upper body. During an observation on 5/20/26 at 3:56 p.m., with the FM-D, video footage from the video camera in R2's room which was not dated or timed, revealed one staff dressing R2. During an interview on 5/20/26 at 4:23 p.m., the FM-D stated she had video footage from the camera in R2's room that showed one staff dressing R2 when it should have been two staff. The video showed the staff putting her full weight into dressing R2 because it appeared to be too difficult for one staff to manage.	F0656		07/03/2026

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F0656 SS = D	Continued from page 27 During an observation on 5/22/26 at 4:20 p.m., with the director of nursing (DON) review of footage from the video camera in R2's room that was not dated or timed revealed one staff dressing R2. During an interview on 5/22/26 at 4:20 p.m., the DON identified the staff in the video as NA-A, acknowledged the NA-A did not use two staff to dress R2. The DON stated R2's care plan indicated two staff for upper body dressing due R2's upper extremities were difficult to move with only one staff. The DON stated it was not good care provided by the NA-A. During an interview on 5/26/26 at 2:32 p.m., the NA-A stated R2 required the assistance of two staff for dressing because R2's limbs were stiff, and difficult to manage with one staff. The NA-A acknowledged she dressed R2 by herself, didn't know what the care plan directed regarding number of staff to assist with R2 dressing. NA-A stated they could look on R2's Kardex to find out, but hadn't. R4 R4's Medicare 5-Day MDS dated 4/23/26, indicated R4 had intact cognition, was dependent upon staff for activities of daily living (ADLs) including applying footwear. R4 had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure ulcer, diabetes, and diabetic foot ulcers. R4's care plan dated 4/2/26, indicated actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema. Interventions included pressure relief ankle foot orthosis (PRAFO, used to stabilize the ankle, prevent foot drop, and eliminate pressure on the heels) boots on at all times, initiated 5/4/23. During an observation on 5/20/26 at 11:58 a.m., R4's heel protectors were lying on the floor near the end of R4's bed. R4's legs were resting directly on a disposable pad at the end of the bed. During an observation on 5/20/26 at 12:07 p.m., the	F0656		07/03/2026

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F0656 SS = D	Continued from page 28 RN-D entered R4's room to bring R4's meal tray and medication. R4's heel protectors were left lying on the floor near the end of R4's bed when RN-D left R4's room. During an observation on 5/20/26 at 1:19 p.m., R4's heel protectors were lying on the floor near the end of R4's bed, the RN-D and the NA-B entered the room to perform wound care for R4. During wound care, R4 requested the RN-D and NA-B don his protective boots and stated they were to be worn most of the time. When the wound care was completed, both the RN-D and NA-B left the room without donning R4's protective boots. During an interview on 5/20/26 at 2:14 p.m., the RN-D stated R4 was supposed to wear his protective boots as much as possible to help prevent pressure ulcers and acknowledged she did not put them on R4 before leaving his room. During an interview on 5/20/26 at 2:18 p.m., the NA-B acknowledged he did not put R4's protective boots on R4's feet, and stated the boots were used to prevent openings on R4's skin. During a continuous observation on 5/22/26 starting at 1:13 p.m., R4 was in his room and had activated his call light. R4's protective boots were in his recliner. At 1:51 p.m., the NA-C answered R4's call light. R4 asked the NA-C to don his protective boots. The NA-C responded, "Right now? Your aide will be back from break soon." R4 explained to the NA-C that his protective boots should have been put on in the morning, after he was weighed. During an interview on 5/22/26 at 1:13 p.m., R4 stated he asked a NA several times what was sitting in his recliner, and the NA had responded saying only a pillow was in the recliner. R4 stated he had poor vision and could not see what was in his chair for himself, could not feel his legs from his knees to his feet, so he did not know staff had not donned his boots. R4's routine was to have his weight checked daily around 6:30 a.m., and staff would don his boots afterwards to protect his feet and offload his heels. During an interview on 5/22/26 at 2:25 p.m., the NA-D stated he was R4's assigned NA for the	F0656		07/03/2026

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F0656 SS = D	Continued from page 29 morning shift, and R4 had asked what was on his recliner. The NA-D stated he knew from his care sheet R4 was supposed to be wearing his protective boots, but was not because the NA-D had gotten busy and forgot about them. The NA-D acknowledged R4 could develop more wounds if he were not wearing the protective boots. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated if R4's care plan and orders directed for R4 to wear the protective boots, then R4 should have been wearing them. During an interview on 5/26/26 at 3:31 p.m., the DON stated R4 was supposed to always wear the protective boots on his feet when he was in bed to float his heels off the bed. A policy regarding developing and implementing care plans was requested but not provided.	F0656		07/03/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to ensure pressure ulcer (PU) preventative measures indicated on the care plan were implemented for 2 of 4 residents (R2, R4) reviewed for wounds. Findings include:	F0686	Plan of Correction: F0686 – Failure to Implement Pressure Ulcer Preventative Measures • The alleged deficiencies for resident(s) R2 and R4 have been corrected as of 06/20/2026. Interventions Implemented: Immediate review and update of care plans for R2 and R4 to ensure all pressure ulcer (PU) preventative measures are clearly documented and implemented. Direct observation confirmed that all interventions (repositioning schedules, including preferences, use of pressure-relieving devices) are in place for both residents. Immediate re-education provided to assigned nursing staff on the importance of following care plan interventions for PU prevention. Responsible Party: The Director of Nursing (DON) was responsible for implementing these	07/03/2026

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F0686 SS = D	Continued from page 30 R2 R2's annual Minimum Data Set (MDS) dated 5/11/26, indicated severe cognitive impairment, R2 was always incontinent of bowel and bladder, and was at risk for developing PU. R2's diagnoses included dementia and arthritis. R2's care plan dated 5/14/22, revised 5/20/26, indicated R2 had potential impairment to skin integrity related to incontinence, immobility, and medication use with current MASD (moisture associated skin damage) with treatment with an ointment. Interventions added 5/18/26, included: "See the Skin/Wound tab in the medical record for current skin measurements and interventions; treatment as ordered and notify provider if the skin alteration was worsening or shows signs and symptoms of infection or no improvement in fourteen days. " R2's Skin Issues/ Skin Check notes indicated the following: 4/7/26 at 3:38 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft (groove between the buttocks that extends from just below the sacrum to the perineum, containing the anus). The skin check failed to include if education was provided, if family and/or provider were updated and clinical suggestions. 4/14/26 at 3:20 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft. Clinical suggestion indicated apply barrier cream to skin. The skin check failed to include if education was provided and if family and/or provider were updated. The skin assessments lacked indication a skin check was performed on R2 the week of 4/21/26. 4/28/26 at 3:13 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft. The skin check failed to include if family and/or provider were updated and clinical suggestions. 5/5/26 at 12:26 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft. The skin check failed to include if family and/or provider were updated and clinical suggestions.	F0686	Continued from page 30 corrections. • Residents who are at risk for pressure ulcers or have existing wounds have the potential to be affected by the alleged deficient practice. Audits Completed: The DON completed an audit of all current residents with wounds or at high risk for pressure ulcers as of 06/23/2026 to ensure that all care plan interventions are in place and are being followed. No additional residents were found to be affected. • The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: Actions Taken: All licensed nursing staff and certified nursing assistants (CNAs) received in-service training starting on 06/24/2026 regarding: The importance of implementing all care plan interventions for PU prevention. Documentation requirements for PU preventative measures. Reporting and escalation procedures if interventions are not in place. Implementation of a new daily wound care checklist for all residents with a new wound, effective 06/24/2026. Education will be provided for all licensed nursing staff and CNAs regarding the policy and processes begin on 6/23/2026. Education to include implementation checklist for new wounds and wound prevention intervention implementation.	07/03/2026

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F0686 SS = D	Continued from page 31 During an interview on 5/20/26 at 3:56 p.m., the family member (FM)-D stated R2 had a wound on her bottom for the third or fourth time since admission, because facility staff didn't change R2's incontinence brief frequent enough and R2 laid on her backside in bed for hours in a row. The FM-D stated, "If the wounds had been found before they were open, they might not be so painful to clean." During an interview on 5/26 26 at 10:09 a.m., the licensed practical nurse (LPN)-B stated R2 had ongoing MASD. It was possible the treatment was not working because the MASD kept returning. The treatment included to apply a barrier cream and reposition R2 every two to three hours. The LPN-B stated skin checks were performed each week during the resident's bath time. If not completed weekly, skin breakdown not previously identified could be missed. During an interview on 5/26/26 at 12:29 p.m., the nurse practitioner (NP)-A stated if R2 did not get the wound checks and assessments as ordered, new wounds could be missed, or the wounds could get worse. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated staff told the wound team about wounds on R2's bottom, but during assessment, the wound team did not locate the wounds. Pictures of the wounds were sent to the wound care team weekly for two weeks. R2's skin was assessed following each notification of wounds, but the wound team did not find the wounds. After R2's family got upset with the DON, the wound team looked a third time and moved skin folds. Two wounds were noted on R2's perineum (region of the body located between the thighs, between the anus and vaginal opening). The RN-B stated the wounds were likely present during first two assessments but were not seen by the wound team due to R2's body size. RN-B stated with the initial two attempts to find the reported wounds, the wound team did not move R2's skin folds as thoroughly as was done with the third attempt. The RN-B stated she didn't think repositioning in a wheelchair would make a difference, but instead it was the sitting on the area that was likely causing the issue. The RN-B stated she was unsure if that education was provided to the family and did not find any documentation indicating education to the family had occurred. The RN-B acknowledged R2 did not have a skin check the week of 4/21/26 and stated, "New wounds could be missed when the assessments were not done weekly."	F0686	Continued from page 31 On-call or PRN staff not working during this period will receive training prior to their next scheduled shift. • Woodbury Senior Living will monitor performance to ensure sustained compliance. The DON or designee will audit the implementation of PU preventative measures for all at-risk residents three (3) times weekly until consecutive 4 weeks of 100% compliance is obtained. Audit results will be presented to the QAPI committee monthly, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. • Woodbury Senior Living will be in substantial compliance by 07/3/2026 *Prepared by:* Woodbury Senior Living Compliance Team 6/18/2026	07/03/2026

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F0686 SS = D	Continued from page 32 During an interview on 5/26/26 at 3:31 p.m., the DON stated R2 had previous MASD wounds, and then recently staff found them again. Ensuring skin checks are completed timely, education about refusals of care, and keeping R2 as dry as possible were keys to ensure MASD didn't occur. The DON acknowledged R2 did not have a skin check on 4/21/26 but should have and acknowledged skin checks were utilized to discover new skin issues, and skin issues forms were utilized to assess current skin issues, and stated "It could have potentially made a difference if that skin check had been done. I wish we had noticed the wounds sooner." R4 R4's Medicare 5-Day MDS dated 4/23/26, indicated R4 had intact cognition, was dependent upon staff for applying footwear, had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure ulcer, diabetes, and diabetic foot ulcers. R4's care plan indicated the following: 5/4/23 difficulty sleeping 6/13/23 type II Diabetes 6/13/23 altered cardiac status related to congestive heart failure (chronic progressive condition in which the heart cannot pump blood efficiently enough to meet the body's needs) and hypertension (high blood pressure) 7/24/23 peripheral vascular disease (slow progressive circulatory disorder characterized by the narrowing, blockage, or spasms of blood vessels, most commonly reducing blood flow to the arms, legs, and feet 5/12/25 impaired vision 6/30/25 incontinence of bowel 12/12/25 encephalopathy (broad term for any disease, damage, or malfunction that affects the brain's function, with an altered mental state that may include confusion, memory loss, or personality changes) 4/2/26 actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema (chronic condition	F0686		07/03/2026

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F0686 SS = D	Continued from page 33 of build-up of fluid from the lymphatic system (network of tissues, organs, and vessels that maintain fluid balance, absorbs dietary fats, and defends the body against infections and circulates lymph fluid (colorless, watery fluid) throughout the body) in the body's soft tissues, usually in the arms or legs often started with swelling in the hands or feet). Interventions included protecting bony areas with pillows and supportive devices initiated 1/6/22, and pressure relief ankle foot orthosis (PRAFO, used to stabilize the ankle, prevent foot drop, and eliminate pressure on the heels) boots on at all times, initiated 5/4/23. During an observation on 5/20/26 at 11:58 a.m., R4's heel protectors were lying on the floor near the end of R4's bed. R4's legs were resting directly on a disposable pad at the end of the bed. During an observation on 5/20/26 at 12:07 p.m., the RN-D entered R4's room to bring R4's meal tray and medication. R4's heel protectors were left lying on the floor near the end of R4's bed when the RN-D left R4's room. During an observation on 5/20/26 at 1:19 p.m., R4's heel protectors were lying on the floor near the end of R4's bed, the RN-D and the nursing assistant (NA)-B entered the room to perform wound care for R4. During wound care, R4 requested the RN-D and the NA-B don his protective boots and stated they were to be worn most of the time. When the wound care was completed, both the RN-D and the NA-A left the room without donning R4's protective boots. During an interview on 5/20/26 at 2:14 p.m., the RN-D stated R4 was supposed to wear his protective boots as much as possible to help prevent pressure ulcers and acknowledged she did not put them on R4 before leaving his room. During an interview on 5/20/26 at 2:18 p.m., the NA-B acknowledged he did not put R4's protective boots on R4's feet, and stated the boots were used to prevent openings on R4's skin. During a continuous observation on 5/22/26 starting at 1:13 p.m., R4 was in his room, R4's call light was activated. R4's protective boots were sitting in his recliner. At 1:51 p.m., the NA-C answered R4's call light. R4 asked the NA-C to don his protective boots. The NA-C responded, "Right now? Your aide will be back from break soon." R4 explained to the NA-C that his protective boots should have been put on in the morning after being weighed. The NA-C shut R4's door. When the NA-C opened the door	F0686		07/03/2026

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F0686 SS = D	Continued from page 34 again at 1:54 p.m., R4 was wearing the protective boots. During an interview on 5/22/26 at 1:13 p.m., R4 stated he asked a NA several times what was in his recliner, and the NA had responded only a pillow was in the recliner. R4 stated he had poor vision and could not see what was in his chair for himself, could not feel his legs from his knees to his feet, so he did not know staff had not donned his boots. R4's routine was to have his weight checked daily around 6:30 a.m., and staff would don his boots afterwards to protect his feet and offload his heels. During an interview on 5/22/26 at 2:25 p.m., the NA-D stated he was R4's assigned NA for the morning shift, and R4 had asked what was on his recliner. The NA-D stated he knew from his care sheet R4 was supposed to be wearing his protective boots, but was not because the NA-D had gotten busy and had forgotten about them. The NA-D acknowledged R4 could develop more wounds if he were not wearing the protective boots. During an interview on 5/26/26 at 10:36 a.m., the licensed practical nurse (LPN)-D stated R4 legs were supposed to have bandages, black stockings over the bandages, and protective boots over the stockings. "If R4 doesn't wear the protective boots, his wounds can worsen, or he could develop new wounds." During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated if R4's care plan and orders indicated to wear the protective boots, then R4 should have been wearing them. During an interview on 5/26/26 at 3:31 p.m., the DON stated R4 was supposed to always wear the protective boots on his feet when he was in bed to float his heels off the bed, and to prevent new wounds. Without the boots, R4 was at risk for new PU. The Skin Management Program dated 11/2017 indicated the program was utilized to promote the prevention of alterations in skin integrity, promote healing of skin alteration, and to prevent further loss of skin integrity. All residents will be assessed for skin integrity alterations or changes in skin conditions upon preadmission screening, admission, daily within the plan of care, and weekly with a bath. A body audit will be completed weekly, preferably on bath day. Risks for impaired skin integrity included impaired mobility, decreased functional ability, co-morbid conditions such as end stage renal	F0686		07/03/2026

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F0686 SS = D	Continued from page 35 disease, diabetes, obesity, cognitive impairment, exposure to moisture on the skin, resident refusal, pain, and poor sleep. Interventions for skin integrity management included heel protection, skin observations during cares, and management of incontinence.	F0686		07/03/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to follow orders for catheter removal and failed to ensure catheter was in place for a valid medical reason for 1 of 3 residents (R1) reviewed for catheter care.	F0690	Plan of Correction: F0690 – Failure to Follow Orders for Catheter Removal and Ensure Catheter Use for Valid Medical Reason The alleged deficiencies for resident R1 have been reviewed. R1 has since passed away in the hospital. Residents who have indwelling urinary catheters or are at risk for catheterization have the potential to be affected by the alleged deficient practice. The DON has completed audits of all current residents with indwelling catheters as of June 18, 2026 to ensure that each catheter is in place for a valid medical reason and that all physician orders regarding catheter care and removal are being followed. The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: All licensed nursing staff received re-education on the facility's Catheter Care and Removal Policy, including the requirement to follow physician orders, to document valid medical indications for catheter use, and risk/benefit documentation as needed, on June 24, 2026. The Catheter Care and Removal Policy was reviewed as of June 23, 2026 to clarify documentation requirements and the process for verifying ongoing medical necessity. Education will be provided for all licensed nurses, including RNs, LPNs, and charge nurses, regarding the processes. This education will be begin on 6/24/2026. On-call or PRN staff not working during this period will receive training prior to their next scheduled shift.	07/03/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0690 SS = D	Continued from page 36 Findings include: R1's admission Minimum Data Set (MDS) dated 3/15/26, indicated intact cognition, impairment in both upper extremities, dependence upon staff for lower extremity dressing, and diagnoses that included kidney disease, hypertension, liver disease, and a history of urinary tract infection (UTI) in the previous 30 days. R1's provider orders dated 4/18/26, indicated remove the Foley catheter (type of indwelling urinary catheter, used to drain urine from the bladder) on 4/23/26. R1's medication orders indicated the following: 4/18/26 furosemide (diuretic – medication used to promote the production of urine by the kidneys used to flush out excess salt and water) 40 milligrams (mg), starting 4/19/26 give 40 mg by mouth one time daily for acute congestive heart failure (condition where the heart muscle becomes too weak or stiff to pump blood efficiently) for 3 days 4/23/26 furosemide 20 mg, give 20 mg mouth related to congestive heart failure for 3 days for edema, in the morning and evening 4/29/26 Lasix (name brand for furosemide) 40 mg one time a day at 8:00 a.m., and 20 mg one time a day at 1:00 p.m., for edema R1's care plan was reviewed on 5/22/26, and lacked a focus area for R1's Foley catheter. R1's progress notes dated 4/20/26 at 9:28 a.m., as a late entry, indicated R1 was re-admitted to the facility after hospitalization on 4/18/26, with diagnoses that included septic shock (serious medical condition that occurs when an infection leads to dangerously low blood pressure and organ failure), lymphedema (swelling caused by accumulation of protein-rich fluid in the body's tissues), heart failure, elevated liver function tests and was treated with antibiotics for UTI. R1 had a Foley catheter placed, to be removed in three-to-five days. R1's progress notes dated 4/23/26 at 2:42 p.m., indicated registered nurse (RN)-A spoke with	F0690	Continued from page 36 Woodbury Health Care Center will monitor performance to ensure sustained compliance. The DON or designee will audit all residents with indwelling catheters, reviewing documentation for valid medical indications and adherence to physician orders, 5 times weekly until a consecutive 4 weeks of 100% compliance is reached. Audit results will be presented to the QAPI committee, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. Woodbury Senior Living will be in substantial compliance by 07/3/2026	07/03/2026

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F0690 SS = D	Continued from page 37 R1's provider and received the order to keep the Foley catheter inserted because the resident did not want to be turned for brief changes. R1 would need frequent brief changes because she had started taking a diuretic. If R1 refused to be changed, she could have moisture associated skin damage. The progress note lacked mention of education to R1 about the risks and benefits of leaving the catheter inserted. R1's provider noted dated 4/29/26, indicated R1 had an indwelling Foley catheter for comfort because R1 was taking a diuretic. During an interview on 5/19/26 at 11:33 a.m., hospital social worker (SW)-A stated when R1 discharged from the hospital on 4/18/26, the catheter was supposed to be removed within five days, but when R1 readmitted to the hospital, R1 still had a catheter. During an interview on 5/21/26 at 2:46 p.m., family member (FM)-A stated R1 had an indwelling urinary catheter. R1 did not want it out because R1 had started taking a diuretic. Without the catheter R1 would require more frequent incontinence brief changes and bed linen changes. Staff asked R1 once to change the catheter, but R1 refused. Staff called R1's FM-B when R1 refused to eat and FM-B would come to the facility to get her to eat but did not call FM-B when R1 refused to have her catheter changed. The FM-A stated when R1 went to the hospital on 5/6/26, she was very sick, and when R1 refused her catheter change on 4/23/26 and 4/27/26, she may have already been sick and may not have understood what she was refusing or why it was important to take it out. During an interview on 5/22/26 at 10:14 a.m., FM-B stated he asked a nurse at the facility if they were going to change or remove R1's catheter and was told they would, but it never happened. FM-B stated he could not remember who he spoke to, nor which day he inquired about the catheter. During an interview on 5/22/26 at 2:54 p.m., registered nurse (RN)-A stated she did not recall the date, but when she attempted to remove R1's catheter, R1 didn't want the catheter removed. When a resident refused care, staff were supposed to provide education about the order, the risks and benefits of refusing care, and notify the provider of the refusal. The RN-A stated she notified the nurse practitioner (NP) R1 didn't want the catheter removed and told the nurse manager. The RN-A stated R1 had the right to refuse because she	F0690		07/03/2026

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F0690 SS = D	Continued from page 38 was alert and oriented. RN-A acknowledged she did not see any indication in the electronic health record education was provided to R1 about why the catheter was supposed to be removed or the risks and benefits of leaving it inserted. During an interview on 5/21/26 at 4:04 p.m., the NP-A stated if R1 returned from the hospital with a urinary tract infection (UTI), then the facility should have changed the catheter. The NP-A stated if R1 refused to allow the catheter change, staff should have reapproached R1 later to try again, talked to family to see if family could reason with her, and should have provided education to R1 about the risks and benefits of leaving the catheter in when it was ordered to be removed. The NP-A stated R1's infection could have gone septic because the catheter was not removed. During an interview on 5/26/26 at 2:46 p.m., the medical director stated a resident should be notified of the risks of leaving a catheter inserted when it was ordered to be removed, it was the resident's primary provider's responsibility to provide the education, make sure the resident understood the education, and document it because leaving the catheter in could cause sepsis. The facility should have tried to remove it, and if that failed, document why it failed. The medical directed expected the facility to document the need for the catheter. "The regulations are clear and very limited for diagnoses related to using an indwelling urinary catheter. It was used for comfort for [R1]. [R1] needed to know the risk of infection, and that infection could lead to sepsis. Communication with the [R1] would have been the most vital point, and the catheter use would be flagged for inappropriate use. [R1] was very frail, very compromised, had melena (dark stool) that indicated a bleed in the upper gastrointestinal area. Her death certificate indicated sepsis and hemorrhagic (severe or excessive bleeding) shock. With her low blood pressure, the bleeding likely caused her death." During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated there were no progress notes that indicated staff or the provider educated R1 about the risks and benefits of leaving the Foley catheter inserted, it was not left for an appropriate reason, and it was the provider's decision, despite it being inappropriate. The Incontinence Policy dated 5/1/26 indicated for residents with urinary incontinence, the facility will ensure that residents are not catheterized unless the	F0690		07/03/2026

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F0690 SS = D	Continued from page 39 resident's clinical condition demonstrates that catheterization was necessary. Residents who enter the facility with an indwelling catheter, or received one while in the facility, will be assessed for removal of the catheter as soon as possible, unless the resident's clinical condition demonstrates that catheterization was necessary.	F0690		07/03/2026
F0825 SS = D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure lymphedema (swelling caused by an accumulation of protein-rich fluid in the body's tissues) care was provided as ordered for 1 of 4 residents (R1) reviewed for wound care. Findings include: R1's admission Minimum Data Set (MDS) dated 3/15/26, indicated intact cognition, impairment in both upper extremities, and dependence upon staff for lower extremity dressing. R1's diagnoses included kidney disease, hypertension, and liver disease. R1's Hospitalist Discharge Summary dated 4/18/26,	F0825	Plan of Correction: F0825 – Provide/Obtain Specialized Rehab Services for Lymphedema Care The alleged deficiencies for resident R1 have been reviewed, resident has since passed away in the hospital. Residents who receive lymphedema services have the potential to be affected by the alleged deficient practice. The DON has completed audits of all residents with lymphedema orders as of 06/18/2026 to ensure that care is being provided as ordered and that no other residents were affected. No other deficient practices were found. The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: Director of Nursing reviewed with therapy on lymphedema practice and therapy staffing available to complete treatment with no identified foreseeable staffing concerns. All licensed nursing staff received in-service training on lymphedema care protocols, documentation requirements, and the importance of adhering to physician orders on 06/24/2026. Education will be provided for all licensed nurses, wound care nurses, and certified nursing assistants regarding lymphedema therapy and process. This education will begin on 06/27/2026. On-call or PRN staff not working during this period will receive training prior to their next scheduled shift. Woodbury Senior Living will monitor performance to ensure sustained compliance. The DON or designee	07/03/2026

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F0825 SS = D	Continued from page 40 indicated R1 was admitted 4/11/26 with septic shock (a serious medical condition that occurs when an infection leads to dangerously low blood pressure and organ failure), acute kidney injury, elevated liver function test, chronic lymphedema with significant skin changes, required an increase in hospital resources and staff for care related to severe obesity, and was treated in the intensive care unit (ICU) for the management of septic shock. R1 was stable when transferred back to the facility on 4/18/26. Regular activity was encouraged including getting up in a chair for each meal, consider going to the bathroom routinely while awake, and turn often while in bed. R1's hospital discharge orders dated 4/18/26 indicated the following: After caring for wounds, date the dressing and change dressing prior to each lymphedema physical therapy (PT) wrap change on Mondays, Wednesdays, and Friday (MWF) or as needed (PRN) for saturation, loss of integrity, or soiling. Physical therapy evaluation and treatment: lymphedema treatment R1's provider orders indicated the following: 4/18/26- occupational therapy to evaluate and treat 4/18/26- physical therapy to evaluate and treat 4/20/26- lymphedema treatment 4/23/26- wrap bilateral lower extremities with Kerlix (gauze wrap) and then ACE wraps (compression wraps) one time a day for edema, on in the morning, off at bedtime R1's April 2026 Treatment Administration Record (TAR) indicated the following: Kerlix wraps resumed as ordered on 4/24/26 R1's care plan dated 3/27/26, indicated R1 wore ACE wraps, on in the morning, and off at bedtime. The care plan lacked the indication for use and lacked mention of lymphedema treatment with compression and leg pumps.	F0825	Continued from page 40 will audit lymphedema documentation and care delivery twice weekly for a minimum of three months. Audit results will be presented to the QAPI committee, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. Woodbury Senior Living will be in substantial compliance by 07/3/2026.	07/03/2026

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F0825 SS = D	Continued from page 41 R1's PT Encounter Notes indicated the following: 4/20/26- R1 would not allow the PT to touch her legs due to pain, unable lift either leg from the surface of the bed. 4/22/26- R1 seen for evaluation of lymphedema and reported severe pain with light touch of either leg, severely progressed lymphedema to stage 4 (the most severe and advanced stage characterized by massive swelling, significant skin thickening, scarring, and wart-like growths that can severely limit mobility which can result in persistently heavy, achy, and fluid leakage areas of the skin). Measurements of the right lower extremity girth had significantly increased. Recommend proceeding with compression at the discretion of the doctor due to open areas and weeping of the skin. R1 would not be able to tolerate wrapping her legs in the current condition due to pain, but benefit from using her lymphedema pumps (medical machines that are rhythmic, forced air to inflate a specialized sleeve worn over a swollen limb that reduce swelling by mimicking natural lymphatic massage, gently pushing excess lymph fluid out of the extremities and back towards the core for circulation) if allowed. During an interview on 5/21/26 at 2:46 p.m., the family member (FM)-A stated R1 was admitted to the facility for lymphedema care because R1 and FM-A were told the facility had a lymphedema specialist. "We were told they had the position open for months but could not fill the position. The person who used to wrap them at a previous facility offered to come to the facility to train the staff how to wrap [R1's] legs properly, but was told the staff knew how to wrap them, and didn't allow that person to come." During an interview on 5/21/26 at 4:04 p.m., the nurse practitioner (NP)-A stated R1 was supposed to have lymphedema treatment. The facility had a lymphedema specialist who resigned. The facility could have sent R1 out for lymphedema therapy but had not. Nursing staff were doing wraps instead. During an interview on 5/22/26 at 10:14 a.m., the FM-B stated R1 was supposed to have compression pumps to treat lymphedema and was supposed to wear them for a couple of hours a day. The facility staff told the FM-B they didn't want to do it because they didn't have an order for it. The FM-B didn't understand why the facility couldn't get an	F0825		07/03/2026

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F0825 SS = D	Continued from page 42 order to use them. The FM-B stated he was having to help with the compression pumps but that was the service they were paying for. The FM-B stated he assisted R1 with the pumps every other day because the facility staff would not do it. During an interview on 5/22/26 at 11:22 a.m., the admissions coordinator (AC)-A stated R1 had orders for lymphedema care upon admission, which used to be managed by the therapy department, but was now managed by the nursing department. When R1 was admitted to the facility on 4/18/26, her orders indicated PT lymphedema treatment, and on 3/12/26 R1 had orders from the hospital for PT lymphedema treatment. The facility should not have taken R1 if she didn't have orders for the compression pumps, or if PT staff were not available manage the treatments. During an interview on 5/22/26 at 11:54 a.m., the physical therapist (PT)-A stated R1 used compression pumps at home and another facility prior to admission to this facility. R1 was able to demonstrate how to correctly use the pumps. The therapy department advocated for R1 to continue to use the compression pumps because R1's legs got very large with fluid, and the pumps would have helped push some of the fluid out of her legs. The PT-A stated the facility director of nursing (DON) did not allow R1 to use the pumps initially because the nursing department was not familiar with the pumps. Then the DON wouldn't allow R1 to use them out of fear R1 could not shut the pump off if she needed to. R1 demonstrated to the therapy department that she could turn the power off, and unzip the compression sleeves. R1 further demonstrated she understood the settings on the pumps, but was still not allowed to use them. The PT-A stated R1's hospital orders indicated she was supposed to have PT lymphedema therapy which was available for a couple of days a week when R1 admitted to the facility, but not for the daily treatment she needed. The PT staff who was trained to do lymphedema treatment was only on site twice a week, and having just come from the hospital, that would not have been enough to manage the lymphedema. The PT department was trying to eliminate the barriers to using the pumps, but they were just not allowed. During an interview on 5/22/26 at 2:54 p.m., the registered nurse (RN)-A stated the therapy department provided lymphedema care for R1, the nursing staff placed bandages and ACE wraps on	F0825		07/03/2026

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F0825 SS = D	Continued from page 43 R1's legs for lymphedema, and R1's husband put lymphedema pumps on R1's legs. The nursing staff was not trained for lymphedema care. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated R1 did not have a care plan for lymphedema care because nursing staff was not trained for lymphedema care. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated R1 was admitted to the facility with orders for lymphedema wraps for her legs, which the facility therapy department provided but at some point (the DON didn't know the date), the therapy department deferred R1's lymphedema care to the nursing staff. Instead, R1's family member was managing R1's compression wraps and pumps. There was a six-to-seven-day delay for the therapy department to do the assessment to ensure R1 and her family member knew how to use the pumps. It should not have taken that long. The nursing staff was not trained to use compression sleeves and pumps. It was 3/25/26 when therapy stated she could use them. The DON stated she was unsure why the PT notes indicated on 4/22/26 R1 would benefit from using them, R1 should have been using them, with the help from her husband, but the DON was unsure if they were in use. The DON stated the delay in care for the lymphedema pumps could have contributed to R1's legs swelling more. A policy about lymphedema care was requested but not provided.	F0825		07/03/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	Plan of Correction: F0880 – Infection Prevention & Control: Hand Hygiene and Glove Use During Wound Care Tag Number & Description: F0880 – The facility failed to maintain an effective infection prevention and control program by ensuring staff utilized proper hand hygiene and appropriate glove use during wound care treatments for 1 of 1 resident (R4) reviewed for wound care.	07/03/2026

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F0880 SS = D	Continued from page 44 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport	F0880	Continued from page 44 The alleged deficiencies for resident R4 have been corrected as of June 20, 2026. Immediate interventions included re-educating the staff member involved on proper hand hygiene and glove use per facility policy prior to next scheduled shift. The Director of Nursing (DON)/designee was responsible for implementing these corrections. Residents who receive wound care or other treatments requiring hand hygiene and glove use have the potential to be affected by the alleged deficient practice. The Infection Preventionist has completed random audits of residents currently receiving wound care as of June 23, 2026 to ensure no other residents were affected as well as hand hygiene audits. Measures and Systemic Changes All nursing staff were re-educated on the facility's Infection Prevention and Control Program, with emphasis on hand hygiene and glove use during wound care, on June 23, 2026. The wound care procedure was reviewed with nursing staff including hand hygiene. Education will be provided for all licensed nurses, certified nursing assistants regarding the hand hygiene procedures. This education will begin on 06/24/2026. On-call or PRN staff not working during this period will receive training prior to their next scheduled shift. Monitoring and Quality Assurance Woodbury Senior Living will monitor performance to ensure sustained compliance. The Infection Preventionist or designee will audit wound care procedures and staff hand hygiene/glove use twice weekly until a minimum of 4 weeks of 100% compliance has been met. Audit results will be presented to the QAPI committee monthly, which will review and provide feedback on audit frequency, content, and additional interventions if indicated.	07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/26/2026

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

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F0880 SS = D	Continued from page 45 linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and document review, the facility failed to maintain an effective infection prevention and control program by ensuring staff utilized proper hand hygiene and appropriate glove use during wound care treatments for 1 of 1 resident (R4) reviewed for wound care. Findings include: R4's Medicare 5-Day Minimum Data Set (MDS) dated 4/23/26 indicated R4 had intact cognition, was dependent upon staff for activities of daily living (ADLs) including applying footwear, had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure ulcer (a severe wound with full-thickness skin and tissue loss where true depth and severity of the damage cannot be determined), diabetes, and diabetic foot ulcers . R4's care plan indicated the following: 4/21/25- chronic methicillin-resistant Staphylococcus aureus (MRSA, bacteria that have developed resistance to common antibiotics) in wounds requiring standard precautions for infection control 6/30/25- incontinence of bowel 4/2/26- actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema (swelling caused by an accumulation of protein-rich fluid in the body's tissues). Interventions include treatments as ordered, initiated 1/6/22. R4's wound care orders dated 5/19/26, for wounds on bilateral lower legs and heel indicated the following: Cleanse the wound bed with Vashe (professional	F0880	Continued from page 45 Woodbury Senior Living will be in substantial compliance by 07/3/2026	07/03/2026

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F0880 SS = D	Continued from page 46 grade wound cleansing solution) and pat dry Place silver non-adherent contact layer – green package – cut to fit wound, over open wounds. Cover with 4 x 4 gauze or abdominal pad (ABD) and secure with Kerlix (gauze for wrapping around the leg) Change every 48 hours or as needed for saturation, soiling, or dislodgement. During an observation on 5/20/26 at 1:10 p.m., the registered nurse (RN)-D provided wound care for R4. The RN-D cleansed the wound on R4's right leg, doffed her gloves and then donned clean gloves without performing hand hygiene between glove changes. R4 asked the RN-D to don his compression stocking on his right leg before performing wound care on the left leg. The RN-D donned R4's right compression stocking and then removed the dirty bandages from R4's left leg. R4 cleaned the wound and applied clean bandages over the wounds on R4's left leg without changing gloves. During an interview on 5/20/26 at 2:14 p.m., the RN-D acknowledged she was supposed to perform hand hygiene between gloves changes, and change gloves after removing soiled dressings, before applying clean dressings to prevent infection, but had not because she forgot. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated when performing wound care, nurses should change gloves between touching anything dirty and anything clean and between wounds. The DON expect the nurse to perform hand hygiene in between gloves changes to prevent infection in the wounds. An infection control policy for wound care was requested but not provided.	F0880		07/03/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/20/26, 5/21/26, 5/22/26, and 5/26/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H52352117C (3007404) with licensing orders issued at 0835, 0900,	20000		06/17/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/26/2026**

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20000	Continued from page 1 and 1510. As a result of the investigation a licensing order was issued at 0565. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		06/17/2026
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	20565	Plan of Correction: F0656 – Comprehensive Care Plans • The alleged deficiencies for resident(s) R1, R2, and R4 have been corrected as of 06/20/2026.	07/03/2026

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20565	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review, the facility failed to develop a comprehensive care plan for 1 of 4 resident (R1) reviewed for compressive care plan. Additionally, based on interviews, observations, and document review, the facility failed to implement care planned interventions for 2 of 4 residents (R2, R4) reviewed for care plan implementation. Findings include: R1 R1’s admission Minimum Data Set (MDS) dated 3/15/26, indicated intact cognition, impairment in both upper extremities, dependence upon staff for lower extremity dressing. R1's diagnoses included kidney disease, hypertension, and liver disease. R1’s orders dated 4/23/26, indicated wrap bilateral lower extremities with Kerlix and then ACE wraps, one time a day for edema, on in the morning, off at bedtime. R1’s care plan dated 3/27/26, indicated R1 wore ACE wraps, on in the morning, and off at bedtime. The care plan lacked the indication for use and lacked mention of lymphedema (swelling caused by accumulation of protein-rich fluid in the body's tissues) treatment with compression and pumps. During an interview on 5/21/26 at 2:46 p.m., the family member (FM)-A stated R1 was admitted to the facility for lymphedema care. During an interview on 5/22/26 at 11:22 a.m., the admissions coordinator (AC)-A stated R1 had orders for lymphedema care upon admission, which used to be managed by the therapy department, but was now managed by the nursing department. During an interview on 5/22/26 at 2:54 p.m., the registered nurse (RN)-A stated the therapy department provided lymphedema care for R1. Nursing placed bandages and ACE wraps on R1’s legs for lymphedema, and R1’s husband put lymphedema pumps on R1’s legs. The RN-A stated she was unsure if R1 had a care plan for lymphedema care, but all care interventions required a care plan. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated R1 did not have a care	20565	Continued from page 2 For R1, resident has since passed away in the hospital. For R2, nursing staff that were not following the care plan received immediate education and follow up on 5/25/2026 prior to next assigned shift worked. R4, Direct care staff received immediate education on the importance of following care plans as written on 6/22/2026 The Director of Nursing (DON)/designee was responsible for implementing these corrections. • Residents who require comprehensive care plans and/or have care planned interventions have the potential to be affected by the alleged deficient practice. The DON completed audits of all current residents’ care plans and care plan implementation documentation of residents who require 2 assist for adl's, those with compression intervention, and those with skin protective devices as of 06/22/2026 to ensure no other residents were affected. • The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: All licensed nursing staff members received in-service training on the development, review, and implementation of comprehensive care plans starting on 06/24/2026. Education will be provided for all licensed nurses and certified nursing assistants regarding the processes for care plan implementation and following the care plan with a focus on skin protective interventions and edema management. This education will begin 06/24/2026. On-call or PRN staff not working during this period will receive training prior to their next scheduled shift.	07/03/2026

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20565	Continued from page 3 plan for lymphedema care because nursing staff was not trained for lymphedema care, only for the bandages and ACE wraps. RN-B acknowledged ACE wraps were mentioned on R1's care plan but the care plan did not indicate why. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated R1 was admitted to the facility with orders for lymphedema wraps for her legs, which the facility therapy department provided but at some point (the DON didn't know the date), the therapy department deferred R1's lymphedema care to the nursing staff. R1's family member was managing R1's compression wraps and pumps. The DON acknowledged R1's care plan did not include focus areas or interventions for staff or R1's family to manage R1's lymphedema care but should have. This was important so staff would know how to manage the lymphedema care. R2 R2's annual MDS dated 5/11/26, indicated severe cognitive impairment. R2 was always incontinent of bowel and bladder, was at risk for developing pressure ulcers (PU), and had diagnoses that included dementia and arthritis. R2's care plan dated 4/21/25, indicated two staff were required to dress R2's upper body. During an observation on 5/20/26 at 3:56 p.m., with the FM-D, video footage from the video camera in R2's room which was not dated or timed, revealed one staff dressing R2. During an interview on 5/20/26 at 4:23 p.m., the FM-D stated she had video footage from the camera in R2's room that showed one staff dressing R2 when it should have been two staff. The video showed the staff putting her full weight into dressing R2 because it appeared to be too difficult for one staff to manage. During an observation on 5/22/26 at 4:20 p.m., with the director of nursing (DON) review of footage from the video camera in R2's room that was not dated or timed revealed one staff dressing R2. During an interview on 5/22/26 at 4:20 p.m., the DON identified the staff in the video as NA-A, acknowledged the NA-A did not use two staff to dress R2. The DON stated R2's care plan indicated two staff for upper body dressing due R2's upper extremities were difficult to move with only one staff. The DON stated it was not good care provided by	20565	Continued from page 3 • Woodbury Health Care Center will monitor performance to ensure sustained compliance. The DON or designee will audit 1 quarterly care plan review and implementation documentation 3 times weekly until 4 weeks consecutive compliance is met. Audit results will be presented to the QAPI committee monthly, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. • Woodbury Senior Living will be in substantial compliance by 07/3/2026.	07/03/2026

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20565	Continued from page 4 the NA-A. During an interview on 5/26/26 at 2:32 p.m., the NA-A stated R2 required the assistance of two staff for dressing because R2's limbs were stiff, and difficult to manage with one staff. The NA-A acknowledged she dressed R2 by herself, didn't know what the care plan directed regarding number of staff to assist with R2 dressing. NA-A stated they could look on R2's Kardex to find out, but hadn't. R4 R4's Medicare 5-Day MDS dated 4/23/26, indicated R4 had intact cognition, was dependent upon staff for activities of daily living (ADLs) including applying footwear. R4 had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure ulcer, diabetes, and diabetic foot ulcers. R4's care plan dated 4/2/26, indicated actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema. Interventions included pressure relief ankle foot orthosis (PRAFO, used to stabilize the ankle, prevent foot drop, and eliminate pressure on the heels) boots on at all times, initiated 5/4/23. During an observation on 5/20/26 at 11:58 a.m., R4's heel protectors were lying on the floor near the end of R4's bed. R4's legs were resting directly on a disposable pad at the end of the bed. During an observation on 5/20/26 at 12:07 p.m., the RN-D entered R4's room to bring R4's meal tray and medication. R4's heel protectors were left lying on the floor near the end of R4's bed when RN-D left R4's room. During an observation on 5/20/26 at 1:19 p.m., R4's heel protectors were lying on the floor near the end of R4's bed, the RN-D and the NA-B entered the room to perform wound care for R4. During wound care, R4 requested the RN-D and NA-B don his protective boots and stated they were to be worn most of the time. When the wound care was completed, both the RN-D and NA-B left the room without donning R4's protective boots. During an interview on 5/20/26 at 2:14 p.m., the RN-D stated R4 was supposed to wear his protective boots as much as possible to help prevent pressure ulcers and acknowledged she did not put them on R4 before leaving his room.	20565		07/03/2026

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20565	Continued from page 5 During an interview on 5/20/26 at 2:18 p.m., the NA-B acknowledged he did not put R4's protective boots on R4's feet, and stated the boots were used to prevent openings on R4's skin. During a continuous observation on 5/22/26 starting at 1:13 p.m., R4 was in his room and had activated his call light. R4's protective boots were in his recliner. At 1:51 p.m., the NA-C answered R4's call light. R4 asked the NA-C to don his protective boots. The NA-C responded, "Right now? Your aide will be back from break soon." R4 explained to the NA-C that his protective boots should have been put on in the morning, after he was weighed. During an interview on 5/22/26 at 1:13 p.m., R4 stated he asked a NA several times what was sitting in his recliner, and the NA had responded saying only a pillow was in the recliner. R4 stated he had poor vision and could not see what was in his chair for himself, could not feel his legs from his knees to his feet, so he did not know staff had not donned his boots. R4's routine was to have his weight checked daily around 6:30 a.m., and staff would don his boots afterwards to protect his feet and offload his heels. During an interview on 5/22/26 at 2:25 p.m., the NA-D stated he was R4's assigned NA for the morning shift, and R4 had asked what was on his recliner. The NA-D stated he knew from his care sheet R4 was supposed to be wearing his protective boots, but was not because the NA-D had gotten busy and forgot about them. The NA-D acknowledged R4 could develop more wounds if he were not wearing the protective boots. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated if R4's care plan and orders directed for R4 to wear the protective boots, then R4 should have been wearing them. During an interview on 5/26/26 at 3:31 p.m., the DON stated R4 was supposed to always wear the protective boots on his feet when he was in bed to float his heels off the bed. A policy regarding developing and implementing care plans was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to	20565		07/03/2026

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20565	Continued from page 6 ensure care plans are developed and implemented for residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	20565		07/03/2026
20835	Adequate and Proper Nursing Care; Criteria CFR(s): MN Rule 4658.0520 Subp. 2 A Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to follow orders for catheter removal and failed to ensure catheter was in place for a valid medical reason for 1 of 3 residents (R1) reviewed for catheter care. Findings include: R1's admission Minimum Data Set (MDS) dated 3/15/26, indicated intact cognition, impairment in both upper extremities, dependence upon staff for lower extremity dressing, and diagnoses that included kidney disease, hypertension, liver disease, and a history of urinary tract infection (UTI) in the previous 30 days. R1's provider orders dated 4/18/26, indicated remove the Foley catheter (type of indwelling urinary catheter, used to drain urine from the bladder) on 4/23/26. R1's medication orders indicated the following: 4/18/26 furosemide (diuretic – medication used to promote the production of urine by the kidneys used to flush out excess salt and water) 40 milligrams (mg), starting 4/19/26 give 40 mg by mouth one time daily for acute congestive heart failure (condition where the heart muscle becomes too weak or stiff to	20835	F0690 – Failure to Follow Orders for Catheter Removal and Ensure Catheter Use for Valid Medical Reason The alleged deficiencies for resident R1 have been reviewed. R1 has since passed away in the hospital. Residents who have indwelling urinary catheters or are at risk for catheterization have the potential to be affected by the alleged deficient practice. The DON has completed audits of all current residents with indwelling catheters as of June 18, 2024 to ensure that each catheter is in place for a valid medical reason and that all physician orders regarding catheter care and removal are being followed. The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: All licensed nursing staff received re-education on the facility's Catheter Care and Removal Policy, including the requirement to follow physician orders, to document valid medical indications for catheter use, and risk/benefit documentation as needed, on June 24, 2026. The Catheter Care and Removal Policy was reviewed as of June 23, 2026 to clarify documentation requirements and the process for verifying ongoing medical necessity. Education will be provided for all licensed nurses, including RNs, LPNs, and charge nurses, regarding the processes. This education will begin by 6/24/2026. On-call or PRN staff not working during this period will receive training prior to their next scheduled shift.	07/03/2026

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WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD , WOODBURY, Minnesota, 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
20835	Continued from page 7 pump blood efficiently) for 3 days 4/23/26 furosemide 20 mg, give 20 mg mouth related to congestive heart failure for 3 days for edema, in the morning and evening 4/29/26 Lasix (name brand for furosemide) 40 mg one time a day at 8:00 a.m., and 20 mg one time a day at 1:00 p.m., for edema R1's care plan was reviewed on 5/22/26, and lacked a focus area for R1's Foley catheter. R1's progress notes dated 4/20/26 at 9:28 a.m., as a late entry, indicated R1 was re-admitted to the facility after hospitalization on 4/18/26, with diagnoses that included septic shock (serious medical condition that occurs when an infection leads to dangerously low blood pressure and organ failure), lymphedema (swelling caused by accumulation of protein-rich fluid in the body's tissues), heart failure, elevated liver function tests and was treated with antibiotics for UTI. R1 had a Foley catheter placed, to be removed in three-to-five days. R1's progress notes dated 4/23/26 at 2:42 p.m., indicated registered nurse (RN)-A spoke with R1's provider and received the order to keep the Foley catheter inserted because the resident did not want to be turned for brief changes. R1 would need frequent brief changes because she had started taking a diuretic. If R1 refused to be changed, she could have moisture associated skin damage. The progress note lacked mention of education to R1 about the risks and benefits of leaving the catheter inserted. R1's provider noted dated 4/29/26, indicated R1 had an indwelling Foley catheter for comfort because R1 was taking a diuretic. During an interview on 5/19/26 at 11:33 a.m., hospital social worker (SW)-A stated when R1 discharged from the hospital on 4/18/26, the catheter was supposed to be removed within five days, but when R1 readmitted to the hospital, R1 still had a catheter. During an interview on 5/21/26 at 2:46 p.m., family member (FM)-A stated R1 had an indwelling urinary catheter. R1 did not want it out because R1 had started taking a diuretic. Without the catheter	20835	Continued from page 7 Woodbury Health Care Center will monitor performance to ensure sustained compliance. The DON or designee will audit all residents with indwelling catheters, reviewing documentation for valid medical indications and adherence to physician orders, 5 times weekly until a consecutive 4 weeks of 100% compliance is reached. Audit results will be presented to the QAPI committee, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. Woodbury Senior Living will be in substantial compliance by 07/3/2026	07/03/2026

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20835	Continued from page 8 R1 would require more frequent incontinence brief changes and bed linen changes. Staff asked R1 once to change the catheter, but R1 refused. Staff called R1's FM-B when R1 refused to eat and FM-B would come to the facility to get her to eat but did not call FM-B when R1 refused to have her catheter changed. The FM-A stated when R1 went to the hospital on 5/6/26, she was very sick, and when R1 refused her catheter change on 4/23/26 and 4/27/26, she may have already been sick and may not have understood what she was refusing or why it was important to take it out. During an interview on 5/22/26 at 10:14 a.m., FM-B stated he asked a nurse at the facility if they were going to change or remove R1's catheter and was told they would, but it never happened. FM-B stated he could not remember who he spoke to, nor which day he inquired about the catheter. During an interview on 5/22/26 at 2:54 p.m., registered nurse (RN)-A stated she did not recall the date, but when she attempted to remove R1's catheter, R1 didn't want the catheter removed. When a resident refused care, staff were supposed to provide education about the order, the risks and benefits of refusing care, and notify the provider of the refusal. The RN-A stated she notified the nurse practitioner (NP) R1 didn't want the catheter removed and told the nurse manager. The RN-A stated R1 had the right to refuse because she was alert and oriented. RN-A acknowledged she did not see any indication in the electronic health record education was provided to R1 about why the catheter was supposed to be removed or the risks and benefits of leaving it inserted. During an interview on 5/21/26 at 4:04 p.m., the NP-A stated if R1 returned from the hospital with a urinary tract infection (UTI), then the facility should have changed the catheter. The NP-A stated if R1 refused to allow the catheter change, staff should have reapproached R1 later to try again, talked to family to see if family could reason with her, and should have provided education to R1 about the risks and benefits of leaving the catheter in when it was ordered to be removed. The NP-A stated R1's infection could have gone septic because the catheter was not removed. During an interview on 5/26/26 at 2:46 p.m., the medical director stated a resident should be notified of the risks of leaving a catheter inserted when it was ordered to be removed, it was the resident's primary provider's responsibility to provide the education, make sure the resident	20835		07/03/2026

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20835	Continued from page 9 understood the education, and document it because leaving the catheter in could cause sepsis. The facility should have tried to remove it, and if that failed, document why it failed. The medical directed expected the facility to document the need for the catheter. “The regulations are clear and very limited for diagnoses related to using an indwelling urinary catheter. It was used for comfort for [R1]. [R1] needed to know the risk of infection, and that infection could lead to sepsis. Communication with the [R1] would have been the most vital point, and the catheter use would be flagged for inappropriate use. [R1] was very frail, very compromised, had melena (dark stool) that indicated a bleed in the upper gastrointestinal area. Her death certificate indicated sepsis and hemorrhagic (severe or excessive bleeding) shock. With her low blood pressure, the bleeding likely caused her death.” During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated there were no progress notes that indicated staff or the provider educated R1 about the risks and benefits of leaving the Foley catheter inserted, it was not left for an appropriate reason, and it was the provider’s decision, despite it being inappropriate. The Incontinence Policy dated 5/1/26 indicated for residents with urinary incontinence, the facility will ensure that residents are not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary. Residents who enter the facility with an indwelling catheter, or received one while in the facility, will be assessed for removal of the catheter as soon as possible, unless the resident’s clinical condition demonstrates that catheterization was necessary. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents who utilize urinary catheters to ensure the catheter is for an approved medical reason instead of convenience, and have been provided the necessary education about the risks and benefits of continuing to use the catheter. The director of nursing or designee should conduct measurable audits for a specific amount of time to review catheter use. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21)	20835		07/03/2026

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20835	Continued from page 10 days.	20835		07/03/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to ensure pressure ulcer (PU) preventative measures indicated on the care plan were implemented for 2 of 4 residents (R2, R4) reviewed for wounds. Findings include: R2 R2’s annual Minimum Data Set (MDS) dated 5/11/26, indicated severe cognitive impairment, R2 was always incontinent of bowel and bladder, and was at risk for developing PU. R2's diagnoses included dementia and arthritis. R2’s care plan dated 5/14/22, revised 5/20/26, indicated R2 had potential impairment to skin integrity related to incontinence, immobility, and medication use with current MASD (moisture associated skin damage) with treatment with an ointment. Interventions added 5/18/26, included: "See the Skin/Wound tab in the medical record for current skin measurements and interventions; treatment as ordered and notify provider if the skin alteration was worsening or shows signs and symptoms of infection or no improvement in fourteen days. “	20900	Plan of Correction: F0684 – Quality of Care: Treatment/Services to Prevent/Heal Pressure Ulcers and manage change in condition Deficiency Statement The alleged deficiencies for residents R1, R2, and R4 have been corrected as of June 18, 2026. Immediate interventions included: Comprehensive reassessment of R2, and R4 by the Director of Nursing (DON) or designee. R1 has passed away in the hospital. No current changes in condition noted and wound in improving status. Review of wound care treatment and plan of care for R2 and R4, Reviewed and implemented condition monitoring for affected residents. Immediate education provided to all nursing staff on timely assessment, documentation, and provider notification for changes in resident condition including new skin condition process. The Director of Nursing (DON) was responsible for implementing these corrections. Identification of Other Residents at Risk Residents who have wounds or high risk Braden scores, are at risk for skin breakdown, or have experienced a change in condition have the potential to be affected by the alleged deficient practice. The DON/designee completed audits of all current residents with wounds/risk for wounds or recent changes in condition as of June 23, 2026 to ensure no other residents were affected. Measures and Systemic Changes to Prevent Recurrence	07/03/2026

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20900	Continued from page 11 R2's Skin Issues/ Skin Check notes indicated the following: 4/7/26 at 3:38 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft (groove between the buttocks that extends from just below the sacrum to the perineum, containing the anus). The skin check failed to include if education was provided, if family and/or provider were updated and clinical suggestions. 4/14/26 at 3:20 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft. Clinical suggestion indicated apply barrier cream to skin. The skin check failed to include if education was provided and if family and/or provider were updated. The skin assessments lacked indication a skin check was performed on R2 the week of 4/21/26. 4/28/26 at 3:13 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft. The skin check failed to include if family and/or provider were updated and clinical suggestions. 5/5/26 at 12:26 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft. The skin check failed to include if family and/or provider were updated and clinical suggestions. During an interview on 5/20/26 at 3:56 p.m., the family member (FM)-D stated R2 had a wound on her bottom for the third or fourth time since admission, because facility staff didn't change R2's incontinence brief frequent enough and R2 laid on her backside in bed for hours in a row. The FM-D stated, "If the wounds had been found before they were open, they might not be so painful to clean." During an interview on 5/26 26 at 10:09 a.m., the licensed practical nurse (LPN)-B stated R2 had ongoing MASD. It was possible the treatment was not working because the MASD kept returning. The treatment included to apply a barrier cream and reposition R2 every two to three hours. The LPN-B stated skin checks were performed each week during the resident's bath time. If not completed weekly, skin breakdown not previously identified could be missed. During an interview on 5/26/26 at 12:29 p.m., the nurse practitioner (NP)-A stated if R2 did not get the	20900	Continued from page 11 Staff Training: All licensed nursing staff to receive in-service training on: Timely and thorough assessment/observation of changes in resident condition including abnormal vital signs Documentation requirements for wound care and changes in condition. Immediate provider notification protocols and escalation protocol for any resident exhibiting a change in mentation, responsiveness, or wound status. Training was started on June 24, 2026. On-call and PRN staff will receive this training prior to their next scheduled shift. This education will be completed by the compliance date noted below. Process Changes: Implementation of a "Change in Condition" assessment tool, e-interact change in condition form effective June 22, 2026. Daily monitoring by director of nursing or designee of weekly skin checks to ensure timely implementation of plan of care and daily monitoring of vitals exception reports (abnormal vitals). Procedures "Assessments and Monitoring of Resident Condition" and "Wound Care Management" were reviewed as of June 18, 2026 Monitoring and Quality Assurance Woodbury Health Care Center will monitor performance to ensure sustained compliance. The DON or designee will	07/03/2026

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20900	Continued from page 12 wound checks and assessments as ordered, new wounds could be missed, or the wounds could get worse. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated staff told the wound team about wounds on R2's bottom, but during assessment, the wound team did not locate the wounds. Pictures of the wounds were sent to the wound care team weekly for two weeks. R2's skin was assessed following each notification of wounds, but the wound team did not find the wounds. After R2's family got upset with the DON, the wound team looked a third time and moved skin folds. Two wounds were noted on R2's perineum (region of the body located between the thighs, between the anus and vaginal opening). The RN-B stated the wounds were likely present during first two assessments but were not seen by the wound team due to R2's body size. RN-B stated with the initial two attempts to find the reported wounds, the wound team did not move R2's skin folds as thoroughly as was done with the third attempt. The RN-B stated she didn't think repositioning in a wheelchair would make a difference, but instead it was the sitting on the area that was likely causing the issue. The RN-B stated she was unsure if that education was provided to the family and did not find any documentation indicating education to the family had occurred. The RN-B acknowledged R2 did not have a skin check the week of 4/21/26 and stated, "New wounds could be missed when the assessments were not done weekly." During an interview on 5/26/26 at 3:31 p.m., the DON stated R2 had previous MASD wounds, and then recently staff found them again. Ensuring skin checks are completed timely, education about refusals of care, and keeping R2 as dry as possible were keys to ensure MASD didn't occur. The DON acknowledged R2 did not have a skin check on 4/21/26 but should have and acknowledged skin checks were utilized to discover new skin issues, and skin issues forms were utilized to assess current skin issues, and stated "It could have potentially made a difference if that skin check had been done. I wish we had noticed the wounds sooner." R4 R4's Medicare 5-Day MDS dated 4/23/26, indicated R4 had intact cognition, was dependent upon staff for applying footwear, had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure	20900	Continued from page 12 audit: All new changes in condition for assessment and skin check documentation for implementation of new skin condition process, Three times weekly until 4 weeks of consecutive compliance of 100% is reached Audit results will be presented to the QAPI committee monthly, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. Compliance Date Woodbury Healthcare Center will be in substantial compliance by 07/3/2026	07/03/2026

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20900	Continued from page 13 ulcer, diabetes, and diabetic foot ulcers. R4's care plan indicated the following: 5/4/23 difficulty sleeping 6/13/23 type II Diabetes 6/13/23 altered cardiac status related to congestive heart failure (chronic progressive condition in which the heart cannot pump blood efficiently enough to meet the body's needs) and hypertension (high blood pressure) 7/24/23 peripheral vascular disease (slow progressive circulatory disorder characterized by the narrowing, blockage, or spasms of blood vessels, most commonly reducing blood flow to the arms, legs, and feet 5/12/25 impaired vision 6/30/25 incontinence of bowel 12/12/25 encephalopathy (broad term for any disease, damage, or malfunction that affects the brain's function, with an altered mental state that may include confusion, memory loss, or personality changes) 4/2/26 actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema (chronic condition of build-up of fluid from the lymphatic system (network of tissues, organs, and vessels that maintain fluid balance, absorbs dietary fats, and defends the body against infections and circulates lymph fluid (colorless, watery fluid) throughout the body) in the body's soft tissues, usually in the arms or legs often started with swelling in the hands or feet). Interventions included protecting bony areas with pillows and supportive devices initiated 1/6/22, and pressure relief ankle foot orthosis (PRAFO, used to stabilize the ankle, prevent foot drop, and eliminate pressure on the heels) boots on at all times, initiated 5/4/23. During an observation on 5/20/26 at 11:58 a.m., R4's heel protectors were lying on the floor near the end of R4's bed. R4's legs were resting directly on a disposable pad at the end of the bed. During an observation on 5/20/26 at 12:07 p.m., the RN-D entered R4's room to bring R4's meal tray and medication. R4's heel protectors were left lying	20900		07/03/2026

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20900	Continued from page 14 on the floor near the end of R4's bed when the RN-D left R4's room. During an observation on 5/20/26 at 1:19 p.m., R4's heel protectors were lying on the floor near the end of R4's bed, the RN-D and the nursing assistant (NA)-B entered the room to perform wound care for R4. During wound care, R4 requested the RN-D and the NA-B don his protective boots and stated they were to be worn most of the time. When the wound care was completed, both the RN-D and the NA-A left the room without donning R4's protective boots. During an interview on 5/20/26 at 2:14 p.m., the RN-D stated R4 was supposed to wear his protective boots as much as possible to help prevent pressure ulcers and acknowledged she did not put them on R4 before leaving his room. During an interview on 5/20/26 at 2:18 p.m., the NA-B acknowledged he did not put R4's protective boots on R4's feet, and stated the boots were used to prevent openings on R4's skin. During a continuous observation on 5/22/26 starting at 1:13 p.m., R4 was in his room, R4's call light was activated. R4's protective boots were sitting in his recliner. At 1:51 p.m., the NA-C answered R4's call light. R4 asked the NA-C to don his protective boots. The NA-C responded, "Right now? Your aide will be back from break soon." R4 explained to the NA-C that his protective boots should have been put on in the morning after being weighed. The NA-C shut R4's door. When the NA-C opened the door again at 1:54 p.m., R4 was wearing the protective boots. During an interview on 5/22/26 at 1:13 p.m., R4 stated he asked a NA several times what was in his recliner, and the NA had responded only a pillow was in the recliner. R4 stated he had poor vision and could not see what was in his chair for himself, could not feel his legs from his knees to his feet, so he did not know staff had not donned his boots. R4's routine was to have his weight checked daily around 6:30 a.m., and staff would don his boots afterwards to protect his feet and offload his heels. During an interview on 5/22/26 at 2:25 p.m., the NA-D stated he was R4's assigned NA for the morning shift, and R4 had asked what was on his recliner. The NA-D stated he knew from his care sheet R4 was supposed to be wearing his protective boots, but was not because the NA-D had gotten busy and had forgotten about them. The NA-D acknowledged R4 could develop more wounds if he	20900		07/03/2026

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20900	Continued from page 15 were not wearing the protective boots. During an interview on 5/26/26 at 10:36 a.m., the licensed practical nurse (LPN)-D stated R4 legs were supposed to have bandages, black stockings over the bandages, and protective boots over the stockings. "If R4 doesn't wear the protective boots, his wounds can worsen, or he could develop new wounds." During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated if R4's care plan and orders indicated to wear the protective boots, then R4 should have been wearing them. During an interview on 5/26/26 at 3:31 p.m., the DON stated R4 was supposed to always wear the protective boots on his feet when he was in bed to float his heels off the bed, and to prevent new wounds. Without the boots, R4 was at risk for new PU. The Skin Management Program dated 11/2017 indicated the program was utilized to promote the prevention of alterations in skin integrity, promote healing of skin alteration, and to prevent further loss of skin integrity. All residents will be assessed for skin integrity alterations or changes in skin conditions upon preadmission screening, admission, daily within the plan of care, and weekly with a bath. A body audit will be completed weekly, preferably on bath day. Risks for impaired skin integrity included impaired mobility, decreased functional ability, co-morbid conditions such as end stage renal disease, diabetes, obesity, cognitive impairment, exposure to moisture on the skin, resident refusal, pain, and poor sleep. Interventions for skin integrity management included heel protection, skin observations during cares, and management of incontinence. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI)	20900		07/03/2026

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20900	Continued from page 16 committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		07/03/2026
21510	SpecializedRehabilitative Services; Provision CFR(s): MN Rule 4658.1200 Subp. 2 A.B. Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the required services from an outside source according to part 4658.0075. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure lymphedema (swelling caused by an accumulation of protein-rich fluid in the body's tissues) care was provided as ordered for 1 of 4 residents (R1) reviewed for wound care. Findings include: R1's admission Minimum Data Set (MDS) dated 3/15/26, indicated intact cognition, impairment in both upper extremities, and dependence upon staff for lower extremity dressing. R1's diagnoses included kidney disease, hypertension, and liver disease. R1's Hospitalist Discharge Summary dated 4/18/26, indicated R1 was admitted 4/11/26 with septic shock (a serious medical condition that occurs when an infection leads to dangerously low blood pressure and organ failure), acute kidney injury, elevated liver function test, chronic lymphedema with significant skin changes, required an increase in hospital resources and staff for care related to severe obesity, and was treated in the intensive care unit (ICU) for the management of septic shock. R1 was stable when transferred back to the facility on 4/18/26. Regular activity was encouraged including getting up in a chair for each meal, consider going to the bathroom routinely while awake, and turn often while in bed. R1's hospital discharge orders dated 4/18/26 indicated the following:	21510	Plan of Correction: F0825 – Provide/Obtain Specialized Rehab Services for Lymphedema Care The alleged deficiencies for resident R1 have been reviewed, resident has since passed away in the hospital. Residents who receive lymphedema services have the potential to be affected by the alleged deficient practice. The DON has completed audits of all residents with lymphedema orders as of 06/18/2026 to ensure that care is being provided as ordered and that no other residents were affected. No other deficient practices were found. The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: Director of Nursing reviewed with therapy on lymphedema practice and therapy staffing available to complete treatment with no identified foreseeable staffing concerns. All licensed nursing staff received in-service training on lymphedema care protocols, documentation requirements, and the importance of adhering to physician orders on 06/24/2026. Education will be provided for all licensed nurses, wound care nurses, and certified nursing assistants regarding lymphedema therapy and process. This education will begin by 06/24/2026. On-call or PRN staff not working during this period will receive training prior to their next scheduled shift. Woodbury Senior Living will monitor performance to ensure sustained compliance. The DON or designee will audit lymphedema documentation and care	07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/26/2026**

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

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21510	Continued from page 17 After caring for wounds, date the dressing and change dressing prior to each lymphedema physical therapy (PT) wrap change on Mondays, Wednesdays, and Friday (MWF) or as needed (PRN) for saturation, loss of integrity, or soiling. Physical therapy evaluation and treatment: lymphedema treatment R1’s provider orders indicated the following: 4/18/26- occupational therapy to evaluate and treat 4/18/26- physical therapy to evaluate and treat 4/20/26- lymphedema treatment 4/23/26- wrap bilateral lower extremities with Kerlix (gauze wrap) and then ACE wraps (compression wraps) one time a day for edema, on in the morning, off at bedtime R1’s April 2026 Treatment Administration Record (TAR) indicated the following: Kerlix wraps resumed as ordered on 4/24/26 R1’s care plan dated 3/27/26, indicated R1 wore ACE wraps, on in the morning, and off at bedtime. The care plan lacked the indication for use and lacked mention of lymphedema treatment with compression and leg pumps. R1’s PT Encounter Notes indicated the following: 4/20/26- R1 would not allow the PT to touch her legs due to pain, unable lift either leg from the surface of the bed. 4/22/26- R1 seen for evaluation of lymphedema and reported severe pain with light touch of either leg, severely progressed lymphedema to stage 4 (the most severe and advanced stage characterized by massive swelling, significant skin thickening, scarring, and wart-like growths that can severely limit mobility which can result in persistently heavy, achy, and fluid leakage areas of the skin). Measurements of the right lower extremity girth had significantly increased. Recommend proceeding with compression at the discretion of the doctor due to open areas and weeping of the skin. R1 would not be able to tolerate wrapping her legs in the current condition due to pain, but benefit from using her lymphedema pumps (medical machines that are rhythmic, forced air to inflate a specialized sleeve	21510	Continued from page 17 delivery twice weekly for a minimum of three months. Audit results will be presented to the QAPI committee, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. Woodbury Senior Living will be in substantial compliance by 07/3/2026.	07/03/2026

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21510	Continued from page 18 worn over a swollen limb that reduce swelling by mimicking natural lymphatic massage, gently pushing excess lymph fluid out of the extremities and back towards the core for circulation) if allowed. During an interview on 5/21/26 at 2:46 p.m., the family member (FM)-A stated R1 was admitted to the facility for lymphedema care because R1 and FM-A were told the facility had a lymphedema specialist. "We were told they had the position open for months but could not fill the position. The person who used to wrap them at a previous facility offered to come to the facility to train the staff how to wrap [R1's] legs properly, but was told the staff knew how to wrap them, and didn't allow that person to come." During an interview on 5/21/26 at 4:04 p.m., the nurse practitioner (NP)-A stated R1 was supposed to have lymphedema treatment. The facility had a lymphedema specialist who resigned. The facility could have sent R1 out for lymphedema therapy but had not. Nursing staff were doing wraps instead. During an interview on 5/22/26 at 10:14 a.m., the FM-B stated R1 was supposed to have compression pumps to treat lymphedema and was supposed to wear them for a couple of hours a day. The facility staff told the FM-B they didn't want to do it because they didn't have an order for it. The FM-B didn't understand why the facility couldn't get an order to use them. The FM-B stated he was having to help with the compression pumps but that was the service they were paying for. The FM-B stated he assisted R1 with the pumps every other day because the facility staff would not do it. During an interview on 5/22/26 at 11:22 a.m., the admissions coordinator (AC)-A stated R1 had orders for lymphedema care upon admission, which used to be managed by the therapy department, but was now managed by the nursing department. When R1 was admitted to the facility on 4/18/26, her orders indicated PT lymphedema treatment, and on 3/12/26 R1 had orders from the hospital for PT lymphedema treatment. The facility should not have taken R1 if she didn't have orders for the compression pumps, or if PT staff were not available manage the treatments. During an interview on 5/22/26 at 11:54 a.m., the physical therapist (PT)-A stated R1 used compression pumps at home and another facility prior to admission to this facility. R1 was able to demonstrate how to correctly use the pumps. The therapy department advocated for R1 to continue to	21510		07/03/2026

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21510	Continued from page 19 use the compression pumps because R1's legs got very large with fluid, and the pumps would have helped push some of the fluid out of her legs. The PT-A stated the facility director of nursing (DON) did not allow R1 to use the pumps initially because the nursing department was not familiar with the pumps. Then the DON wouldn't allow R1 to use them out of fear R1 could not shut the pump off if she needed to. R1 demonstrated to the therapy department that she could turn the power off, and unzip the compression sleeves. R1 further demonstrated she understood the settings on the pumps, but was still not allowed to use them. The PT-A stated R1's hospital orders indicated she was supposed to have PT lymphedema therapy which was available for a couple of days a week when R1 admitted to the facility, but not for the daily treatment she needed. The PT staff who was trained to do lymphedema treatment was only on site twice a week, and having just come from the hospital, that would not have been enough to manage the lymphedema. The PT department was trying to eliminate the barriers to using the pumps, but they were just not allowed. During an interview on 5/22/26 at 2:54 p.m., the registered nurse (RN)-A stated the therapy department provided lymphedema care for R1, the nursing staff placed bandages and ACE wraps on R1's legs for lymphedema, and R1's husband put lymphedema pumps on R1's legs. The nursing staff was not trained for lymphedema care. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated R1 did not have a care plan for lymphedema care because nursing staff was not trained for lymphedema care. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated R1 was admitted to the facility with orders for lymphedema wraps for her legs, which the facility therapy department provided but at some point (the DON didn't know the date), the therapy department deferred R1's lymphedema care to the nursing staff. Instead, R1's family member was managing R1's compression wraps and pumps. There was a six-to-seven-day delay for the therapy department to do the assessment to ensure R1 and her family member knew how to use the pumps. It should not have taken that long. The nursing staff was not trained to use compression sleeves and pumps. It was 3/25/26 when therapy stated she could use them. The DON stated she was unsure why the PT notes indicated on 4/22/26 R1 would benefit from using them, R1 should have been using them, with the help from her husband, but the DON was unsure if they were in	21510		07/03/2026

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21510	Continued from page 20 use. The DON stated the delay in care for the lymphedema pumps could have contributed to R1's legs swelling more. A policy about lymphedema care was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, DON, with assistance from contracted therapy services or designee could review and revise policies and procedures to ensure residents requiring specialized PT lymphedema therapy are provide the required services or obtain those services from an outside source. The administrator, DON, or designee should audit all resident medical records and physician orders and newly admitted resident records to ensure all residents who require services are receiving appropriate therapy according to physician orders and/or assessments, in order to enhance or maintain resident abilities. Those audits should be performed in a measurable way, (ex: weekly x 4 weeks, then monthly x ... etc.) The administrator, DON, or designee should take the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21510		07/03/2026

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F0000	INITIAL COMMENTS On 7/8/26 and 7/9/26, an onsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited on 5/26/26. The facility was NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following tags were recited: F656 and 684. 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. 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.	F0000		07/25/2026
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F0656	Immediate Action Taken: Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. Immediate Action Taken: Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility,	07/25/2026

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 reverse for further 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.

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

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F0656 SS = E	Continued from page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to develop and implement a comprehensive care plan addressing identified fall risk factors for 1 of 5 residents (R5) assessed to be at risk of falls on admission. Additionally, the facility staff failed to implement care-planned interventions for 3 of 5 residents (R4, R6, R7) reviewed for care planned interventions. Findings include: R5 R5’s admission Minimum Data Set (MDS) dated 5/5/26, indicated intact cognition, palliative care (comfort care), an unknown fall history prior to admission and no falls since admission. R5's diagnoses included heart failure, malnutrition, and liver disease.	F0656	Continued from page 1 its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. On 7/8/2026, the Director of Nursing implemented immediate actions to address the concerns identified during the survey by updating R5's care plan to include fall prevention interventions, completing a fall risk assessment, and conducting a post-fall evaluation. Additionally, the nursing staff conducted immediate skin checks for R6 and R7 to ensure their skin integrity was monitored as per the care plan requirements. To ensure R4 received timely incontinence care, the assigned nursing assistant received coaching on the importance of adhering to the care plan and the necessary steps to follow for timely assistance. Incontinent residents on unit were interviewed during mealtimes to ensure needs were met appropriately. Furthermore, an audit of residents at risk for falls was conducted by nursing staff to verify that care plans were updated accordingly. Care plans were reviewed for residents who are dependent with incontinence care, weekly skin checks were reviewed for completion as residents allow, and education was provided to staff regarding refusals of care. Policies regarding following care plans were reviewed and remain current. Scope and Impact Assessment: On July 24th, 2026, the Director of Nursing or designee conducted a comprehensive review of all current residents with identified fall risks to ensure that care plans include appropriate interventions. This audit assessed the scope of care plan deficiencies related to fall risk and the implementation of care-planned interventions. The review identified residents who are at risk for falls or have a history of falls as potentially affected by the lack of comprehensive care plans. Moving forward, On July 24th, the director of nursing or designee will ensure that all care plans for residents at risk of falls are updated to include necessary interventions to promote resident safety and well-being. On 7/24/2026 skin check order sets were reviewed and edited to promote separate documentation of skin check completion and bathing task. Education and Prevention Measures:	07/25/2026

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F0656 SS = E	Continued from page 2 R5's Fall Risk Evaluation dated 4/29/26, indicated R5 had intermittent confusion, was bedbound and was incontinent. R5 had a change in condition in the previous fourteen days, a recent hospitalization in the previous thirty days, received prescribed medications, with a recent change in medications. Based on these factors, R5 was at risk for falls. The evaluation indicated R5 should have a focus area on his care plan for falls that indicated a goal to be free of falls with interventions to evaluate the fall risk on admission and PRN, alert the provider if R5 fell, and to initial frequent neurological and bleeding evaluations per the facility protocol. The Fall Risk Evaluation indicated, "If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented in the care plan." R5's fall risk score for the assessment was 16. R5's care plan reviewed 7/8/26, lacked a care plan focus area for falls and lacked interventions to prevent falls. R5's progress notes dated 7/7/26 at 3:16 p.m., indicated R5 was found on the floor by a nursing assistant (NA). The progress note indicated R5 was able to move all extremities, had no apparent injuries and was assisted off the floor with the assistance of three staff using a full body lift (lift used to move a resident from surface to surface that does not require the resident to bear weight). Further, the progress note indicated R5's vital signs (VS) were WNL (within normal limits) but lacked indication of the VS values/numbers. The progress notes lacked indication the care plan was either reviewed or updated. During an interview on 7/8/26 at 3:01 p.m., the director of nursing stated she did not see a falls care plan in R5's care plan and did not see a care plan update after R5's fall. The DON further stated both should have been present in the medical record. During an interview on 7/9/26 at 3:19 p.m., licensed practical nurse (LPN)-A stated R5 had no injuries from his fall on 7/7/26. After the fall, LPN-A inquired with R5 if he had a head strike, and R5 shook his head in response, and because LPN-A did not identify changes in R5's baseline condition,	F0656	Continued from page 2 On 7/13/2026, the Director of Nursing implemented comprehensive training for nursing staff focused on fall risk evaluations, post-fall evaluations, order sets for post-fall monitoring, and immediate intervention implementation. Additionally, staff received education on the importance of care plan implementation, adherence to care plans, and the care planning process, including necessary updates. Training on skin check procedures, including routine schedules and compliance, was also completed. To prevent future deficiencies, the post-fall protocol was reviewed on 7/13/2026 to ensure it aligns with best practices and skin assessment protocol was reviewed. An audit of all resident care plans has been completed to confirm that fall risk factors and skin assessments are adequately addressed. Ongoing Monitoring Plan: To address the concerns identified during the survey, the Director of Nursing or a designated nurse manager will conduct ongoing audits of the comprehensive care plans to ensure they address all identified risk factors and interventions. Audits will be conducted daily to monitor the implementation of fall processes, weekly skin checks, and the implementation of care plans, including fall interventions. Audits of those requiring two staff for assistance will be audited 3x/weekly. These audits will continue until 100% compliance has been met consistently for four weeks consistently. Findings will be reviewed at the QAPI/Quality Assurance meeting on August 24th, 2026 and thereafter per the facility's QAPI review schedule to ensure continuous improvement and compliance.	07/25/2026

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F0656 SS = E	Continued from page 3 LPN-A did not perform neurological checks. LPN-A acknowledged he did not review R5's care plan after the fall, did not know R5 did not have a falls care plan, and did not add an intervention to the care plan to prevent future falls. LPN-A stated he should have added an intervention to put a floor mat by the bed in case he fell out of bed again but had not and was not aware of any other fall prevention interventions in place for R5. During an interview on 7/9/26 at 4:06 p.m., LPN-B stated after a resident fell, the nurse who assessed R5 should have reviewed R5's care plan and would have known there was no care plan for falls. LPN-B could not recall any fall interventions in place for R5. R4 R4's MDS dated 06/29/26 indicated intact cognition, dependence upon staff for toileting hygiene, activities of daily living (ADL), and occasional incontinence of bowel. R4's diagnoses included dementia, chronic respiratory failure, diabetes, and obesity. R4's care plan indicated the following: 4/21/26- assistance of two staff with care related to history of physical outburst with staff and / or accusations of staff not attempting cares, but the NA-A provided care alone 6/30/26- indicated incontinence of bowel with interventions to provide incontinence care and change the incontinence brief as needed after incontinence episodes R4's call light log indicated R4 activated his call light on 7/6/26 at 12:15 p.m., it was de-activated at 12:20 p.m., re-activated at 12:30 p.m. and de-activated again at 12:42 p.m. During an interview on 7/8/26 at 9:18 a.m., R4 stated on 7/6/26 he activated his call light around lunchtime. The nursing assistant (NA)-A responded, turned off his call light, and stated she was passing trays but was almost done and would come back. R4 stated he told the NA-A he had a bowel movement and was sitting in it. R4 stated the NA-A did not return, so he reactivated his call light and NA-B	F0656		07/25/2026

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F0656 SS = E	Continued from page 4 answered his light but declined to help him because R4 was not assigned to NA-B. R4 stated the NA-B told him he would have to wait until the NA-A returned from break about an hour later. During an interview on 7/8/26 at 9:42 a.m., NA-A stated R4 asked her to change his incontinence brief on 7/6/26, when she was passing lunch trays. NA-A told R4 she would return to help him as soon as she was done passing trays, and only had a few left. When NA-A walked by R4's room, R4 was eating, so NA-A told her team she was going on break and left. NA-A did not tell other staff R4 needed to be changed or telling R4 she was going on break. NA-A stated she was told when she returned from break, R4 reactivated his call light while she was gone, another NA answered the light and refused to change him. NA-A stated she told registered nurse (RN)-B that day about the other NA refusing to change R4. NA-A acknowledged she had not asked R4 if he was ready to be changed before she went on break, and RN-B asked her to change R4 before she went on break, but she did not. NA-A acknowledged she changed R4 herself, without the assistance of other staff as the care plan directed. During an interview on 7/8/26 at 9:50 a.m., RN-B stated on 7/6/26 before lunch time, she informed NA-A R4's call light was on. R4 needed to be changed before lunch and before NA-A took her break. RN-B stated R4 informed her on 7/6/26, a NA answered his light but then would not change him because R4 was not assigned to that NA that day. R4 did not identify the NA to the RN-B. The RN-B stated if an NA answered R4's call light, and R4 stated he needed to be changed, the NA should have performed the task when requested. RN-B stated she observed the NA-A changing R4 after the NA-A returned from break, around 12:15 p.m., and the NA-A did not have a second staff assisting as required. During an interview on 7/8/26 at 12:12 p.m., RN-C stated he did rounds when he arrived to work on 7/8/26 around 11:00 a.m., R4 told him about the incident in which NA-B refused to change him and NA-A didn't return to change him when she said she would. If RN-B asked NA-A to change R4 before going on break, she should have. R6	F0656		07/25/2026

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F0656 SS = E	Continued from page 5 R6's admission MDS dated 6/29/26, indicated intact cognition, risk of developing pressure ulcers (PU), two venous or arterial ulcers and moisture associated skin damage present. R6's diagnoses included malnutrition, lung disease, cellulitis (bacterial skin infection) of the right lower limb, and lymphedema (abnormal tissue swelling due to a buildup of protein-rich lymph fluid (clear, watery fluid that leaks out of blood vessels into the body's tissues). R6's provider orders indicated the following: 6/26/26 at 7:00 a.m., weekly shower or bath, complete skin check assessment, on day shift, every Friday. 7/8/26 at 3:00 p.m., Please complete skin check today. 7/8/26 at 11:30 a.m., skin check not completed, complete today (indicated the scheduled assessment had been missed) R6's July 2026 Treatment Administration record indicated on 7/3/26, R6's weekly bath and skin check were not performed as ordered and was not performed as ordered on 7/8/26. R6's wound care progress note dated 7/5/26 at 1:08 p.m., indicated wound care was performed for bilateral leg wounds. The progress note lacked indication of assessment of other skin areas. R6's care plan dated 7/2/26, indicated potential impairment to skin integrity related to chronic lymphedema with acute infection of venous stasis ulcers, obesity, incontinence, malnutrition, dependence upon staff for transfers, and medication use with interventions for daily wound monitoring dated 7/2/26, and weekly skin inspections and as needed (PRN) dated 7/2/26. R7 R7's annual MDS dated 6/16/26, indicated moderate cognitive impairment, risk of developing PU, and skin tears. R7's diagnoses included heart failure, diabetes, and edema (swelling caused by excess fluid trapped in the body's tissues).	F0656		07/25/2026

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F0656 SS = E	Continued from page 6 R7's care plan dated 9/22/25, indicated a potential or actual impairment to skin integrity related to mobility, incontinence, oxygen dependence, and a biliary drain in the right upper quadrant (medical tube inserted through the skin of the upper right abdomen to relieve a blockage or leakage in the bile duct – tubes that carry bile from the liver and gall bladder into the small intestine), with an intervention for a skin inspection weekly and PRN dated 9/22/25. R7's provider orders dated 3/28/26, indicated perform a weekly shower and skin check. Further information about refusals must be documented in the progress notes with details about reapproaches. R7's July 2026 treatment administration record (TAR) indicated perform weekly shower and skin check every Saturday. The TAR lacked evidence that the shower or skin check was performed and indicated R7 refused some type of care, but did not identity which care. R7's progress notes dated 7/4/26 at 10:00 p.m., indicated the shower was refused, but lacked mention of whether the skin check was still offered, performed, or refused. The progress lacked indication staff reapproached or offered the shower or skin check at a later time or date. During an interview on 7/8/26 at 3:01 p.m., the director of nursing (DON) stated whoever answered the call light was responsible for changing the resident; R4 could not care for himself and required care in pairs because of prior allegations of staff not providing care. The DON stated the skin checks were not completed as ordered for R6 and R7 during the week of 6/28/26 and was not completed for R6 on 7/8/26. The DON did not know why these skin checks were not completed. During an interview on 7/9/26 at 3:19 p.m., the licensed practical nurse (LPN)-A stated the nurses were supposed to perform weekly skin checks on each resident to ensure staff didn't miss new bruises, injuries, or wounds. During an interview on 7/9/26 at 4:06 p.m., the LPN-B stated each resident required weekly skin checks to check for bruises, open areas, or unknown	F0656		07/25/2026

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F0656 SS = E	Continued from page 7 issues so nurses can follow up, notify the providers, and make a care plan to care for the new skin issue. The skin checks were performed weekly after the bath, and if the resident refused the skin check, staff should document it. The Care Planning – Resident Participation policy dated 4/1/26 indicated the care planning process included an assessment of a resident's strengths and needs.	F0656		07/25/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review, the facility failed to comprehensively assess and implement post-fall monitoring, perform a new fall risk assessment after a fall, and initiate post-post prevention interventions for 1 of 3 residents (R5) after a fall. F684 Based on interviews and document review, the facility failed to comprehensively assess and implement post-fall monitoring, perform a new fall risk assessment after a fall, and initiate post-post prevention interventions for 1 of 3 residents (R5) after a fall. Findings include: R5's admission Minimum Data Set (MDS) dated 5/5/26 indicated intact cognition, palliative care (comfort care), an unknown fall history prior to admission, no falls since admission, with diagnoses that included heart failure, malnutrition, and liver disease.	F0684	Immediate Action Taken: Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. On 7/8/2026, the RN manager conducted a fall risk evaluation for Resident R5 and reviewed the fall risk care plan to address the concerns identified during the survey. Additionally, on 7/7/2026, the RN manager updated the post-fall evaluation, ensuring that the care plan was amended to include interventions that assist R5 before breakfast to predict needs and provide visual stimulation. These immediate actions were implemented to enhance the monitoring and assessment processes following R5's fall and to prevent further falls or injuries. Scope and Impact Assessment: On July 24th, 2026, the Director of Nursing or designee conducted a comprehensive review of all recent fall incidents and corresponding documentation to assess the scope and impact of the deficiency related to post-fall monitoring and care plan updates. This assessment identified that residents with a history of falls were potentially affected by the concerns related to the implementation of post-fall assessments and necessary updates to care plans. Moving forward, on	07/25/2026

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F0684 SS = D	Continued from page 8 R5's Fall Risk Evaluation dated 4/29/26 indicated based on intermittent confusion, bedbound and incontinent status, a change in condition in the previous fourteen days, a recent hospitalization in the previous thirty days, prescribed medications, and a recent change in medications, R5 was at risk for falls. The evaluation indicated R5 should have a focus area on his care plan for falls that indicated a goal to be free of falls with interventions to evaluate the fall risk on admission and PRN, alert the provider if R5 fell, and to initial frequent neurological and bleeding evaluations per the facility protocol. The Fall Risk Evaluation indicated, "If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented in the care plan." R5's fall risk score for the assessment was 16. R5's Post Fall Assessment reviewed 7/8/26 was completed and locked by licensed practical nurse (LPN)-A on 9:10 a.m., and indicated the following: R5's fall was not witnessed, It was unknown what R5 was doing at the time of the fall The section that would indicate if an injury occurred as a result of the fall was not completed The provider notification section was not completed The responsible party notification section was not completed VS were not entered Pain was rated as "none" The form lacked any other assessment data. R5's care plan reviewed 7/8/26 lacked interventions to prevent falls. R5's progress notes dated 7/7/26 at 3:16 p.m., indicated R5 was found on the floor by a nursing assistant (NA). The progress note indicated R5 was able to move all extremities, had no apparent injuries and was assisted off the floor with the assistance of three staff using a full body lift (lift used to move a resident from surface to surface that does not require the resident to bear weight). Further, the	F0684	Continued from page 8 7/24/2026, the Director of Nursing will ensure that all fall incidents are thoroughly reviewed and that appropriate actions are taken to enhance the quality of care provided to residents at risk for falls. Education and Prevention Measures: On 7/13/2026, the Director of Nursing implemented comprehensive training for licensed nursing staff on the post-fall protocol, which included incident/risk report completion, fall risk evaluations, post-fall evaluations, immediate intervention implementation, and order set implementation for post-fall monitoring. To ensure understanding and compliance with the post-fall protocol, ongoing education was initiated on the same date. Additionally, an initial audit of recent fall incidents will be conducted by the Director of Nursing or designee to verify that staff are correctly implementing the post-fall protocol, including neurological assessments and vital sign documentation. The post-fall protocol was reviewed on 7/13/2026 to enhance procedures regarding post-fall monitoring, including vital signs and post-fall risk assessments. Ongoing Monitoring Plan: The Director of Nursing (DON) will conduct audits of post-fall assessments and care plan updates daily until 4 weeks of consistent compliance has been met, ensuring compliance with the facility's protocols. Findings will be reviewed at the QAPI/Quality Assurance meeting on August 24th, 2026 and thereafter per the facility's QAPI review schedule to ensure continuous improvement and compliance.	07/25/2026

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F0684 SS = D	Continued from page 9 progress note stated the vital signs were within normal limits; however, the actual vital sign values were not documented in the progress note, Post-Fall Assessment, or EHR vital signs record. The progress notes lacked documentation of a neurological assessment or ongoing neurological monitoring. During an interview on 7/8/26 at 3:01 p.m., the director of nursing (DON) stated R5's Post-Fall Evaluation competed by the LPN-A lacked a lot of necessary data in the check boxes including whether or not an injury, if the reason for the fall was evident or not, and if the resident had/had not gone to the emergency room. Additionally, the form lacked indication VS or a neurological assessment were completed. The DON stated she would have expected the LPN-A to perform a more complete Post-Fall Assessment, and didn't see any follow-up clinical assessments after R5's fall, and a new Falls Risk Assessment should have been completed but was not, and VS values were not recorded after the fall in the progress notes, the Post-Fall Assessment, nor in the VS tab of the electronic health record (EHR). Further, the DON stated the R5's care plan should have been updated after the fall, and acknowledged R5 did not have a care plan for falls prevention. During an interview on 7/9/26 at 1:48 p.m., the registered nurse (RN)-A stated the LPN-A did a Post-Fall Assessment on 7/7/26, but it was missing a lot of information, so on 7/9/26 the RN-A called the LPN-A on the phone to collect more data, and entered the data in the Post-Fall Assessment form completed by the LPN-A on 7/7/26., but the form was still missing necessary data. The RN-A states she was unable to find VS in the EHR that were assessed after R5's fall, and further stated the facility policy indicated after a fall, the VS should be assessed. During an interview on 7/9/26 at 3:19 p.m., the LPN-A stated R5 had no injuries from his fall on 7/7/26. After the fall, the LPN-A inquired with R5 if he had a head strike, and R5 shook his head in response, and because there were no changes in R5's baseline condition, the LPN-A did not perform neurological checks. The LPN-A acknowledged he did not review R5's care plan after the fall, did not know R5 did not have a falls care plan, and did not add an intervention to the care plan to prevent future falls. The LPN-A stated he should have added an intervention to put a floor mat by the bed in case he fell out of bed again but had not. The LPN-A	F0684		07/25/2026

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F0684 SS = D	Continued from page 10 acknowledged he did not preform a new Falls Risk Assessment after R5's fall but should have. Additionally, the LPN-A stated after a fall, subsequent assessments should have been made to ensure no the resident did not have changes in speech, or a change in condition, but acknowledged, he had not reassessed R5 later, nor had he asked other nurses to do it. During an interview on 7/9/26 at 4:06 p.m., the LPN-B stated after a resident fell, the nurse was required to assess for injuries, perform a neurological assessment if the resident hit their head, assess the skin for injuries, and perform VS. The LPN-B stated the VS should be recorded in the progress notes, the VS tab of the EHR, and in the Post-Fall Assessment. The LPN-B further stated a new Fall Risk Assessment should be completed for a resident who fell because the risk changes after a fall. The LPN-B stated after a resident fell, the nurses should assess the resident on subsequent days [post-fall monitoring] because injuries after a fall were not always immediately evident. The Post Fall Protocol lacked a creation date, review date, or revision date. The policy indicated if a known or suspected head strike occurred, complete a neurological focuses evaluation in the EHR. Complete orthostatic blood pressure, blood sugar (if applicable), and VS. Generate post-fall monitoring in the EHR. The post fall investigation included review of medications, psychological and cognitive status, recent changes in functional status, recent laboratory values, and root causes of recent falls. The nurse should initiate a plan of care based on information, and update/modify interventions as needed. The protocol indicated it was critical to address and mitigate adverse events and potential adverse events. Investigations related to falls should be thorough, accurate, fact-based, well documented, concise, and understandable. The documented care did not reflect implementation of the facility's Post Fall Protocol requiring post-fall monitoring, reassessment, care plan updates, and investigation of contributing factors.	F0684		07/25/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/8/26 and 7/9/26 an onsite revisit was completed to follow up on licensing orders issued from the survey exited 5/26/26. The correction order(s) issued at 0565 were NOT corrected. The uncorrected order(s) will remain in effect and will be reviewed at the next onsite visit. The order(s) will be reviewed for possible penalty assessment. The complaint H52352117C (3007404), which was found to be out of compliance and issued at 0565 at the time of the survey, remained out of compliance.	20000		07/25/2026

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

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		07/25/2026
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to develop and implement a comprehensive	20565	Immediate Action Taken: Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written	07/25/2026

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20565	Continued from page 2 care plan addressing identified fall risk factors for 1 of 5 residents (R5) assessed to be at risk of falls on admission. Additionally, the facility staff failed to implement care-planned interventions for 3 of 5 residents (R4, R6, R7) reviewed for care planned interventions. Findings include: R5 R5’s admission Minimum Data Set (MDS) dated 5/5/26, indicated intact cognition, palliative care (comfort care), an unknown fall history prior to admission and no falls since admission. R5's diagnoses included heart failure, malnutrition, and liver disease. R5’s Fall Risk Evaluation dated 4/29/26, indicated R5 had intermittent confusion, was bedbound and was incontinent. R5 had a change in condition in the previous fourteen days, a recent hospitalization in the previous thirty days, received prescribed medications, with a recent change in medications. Based on these factors, R5 was at risk for falls. The evaluation indicated R5 should have a focus area on his care plan for falls that indicated a goal to be free of falls with interventions to evaluate the fall risk on admission and PRN, alert the provider if R5 fell, and to initial frequent neurological and bleeding evaluations per the facility protocol. The Fall Risk Evaluation indicated, “If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented in the care plan.” R5’s fall risk score for the assessment was 16. R5’s care plan reviewed 7/8/26, lacked a care plan focus area for falls and lacked interventions to prevent falls. R5’s progress notes dated 7/7/26 at 3:16 p.m., indicated R5 was found on the floor by a nursing assistant (NA). The progress note indicated R5 was able to move all extremities, had no apparent injuries and was assisted off the floor with the assistance of three staff using a full body lift (lift used to move a resident from surface to surface that does not require the resident to bear weight). Further, the progress note indicated R5’s vital signs (VS) were WNL (within normal limits) but lacked indication of the VS values/numbers. The progress notes lacked indication the care plan was either reviewed or updated.	20565	Continued from page 2 allegation of substantial compliance with federal Medicare and Medicaid requirements. Immediate Action Taken: Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. On 7/8/2026, the Director of Nursing implemented immediate actions to address the concerns identified during the survey by updating R5's care plan to include fall prevention interventions, completing a fall risk assessment, and conducting a post-fall evaluation. Additionally, the nursing staff conducted immediate skin checks for R6 and R7 to ensure their skin integrity was monitored as per the care plan requirements. To ensure R4 received timely incontinence care, the assigned nursing assistant received coaching on the importance of adhering to the care plan and the necessary steps to follow for timely assistance. Incontinent residents were interviewed during mealtime to ensure needs were met appropriately. Furthermore, an audit of residents at risk for falls was conducted by nursing staff to verify that care plans were updated accordingly. Care plans were reviewed for residents who are dependent with incontinence care, weekly skin checks were reviewed for completion as residents allow, and education was provided to staff regarding refusals of care. Policies regarding following care plans were reviewed and remain current. Scope and Impact Assessment: On July 24th, 2026, the Director of Nursing or designee conducted a comprehensive review of all current residents with identified fall risks to ensure that care plans include appropriate interventions. This audit assessed the scope of care plan deficiencies related to fall risk and the implementation of care-planned interventions. The review identified residents who are at risk for falls or have a history of falls as potentially affected by the lack of comprehensive care plans. Moving forward,	07/25/2026

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20565	Continued from page 3 During an interview on 7/8/26 at 3:01 p.m., the director of nursing stated she did not see a falls care plan in R5's care plan and did not see a care plan update after R5's fall. The DON further stated both should have been present in the medical record. During an interview on 7/9/26 at 3:19 p.m., licensed practical nurse (LPN)-A stated R5 had no injuries from his fall on 7/7/26. After the fall, LPN-A inquired with R5 if he had a head strike, and R5 shook his head in response, and because LPN-A did not identify changes in R5's baseline condition, LPN-A did not perform neurological checks. LPN-A acknowledged he did not review R5's care plan after the fall, did not know R5 did not have a falls care plan, and did not add an intervention to the care plan to prevent future falls. LPN-A stated he should have added an intervention to put a floor mat by the bed in case he fell out of bed again but had not and was not aware of any other fall prevention interventions in place for R5. During an interview on 7/9/26 at 4:06 p.m., LPN-B stated after a resident fell, the nurse who assessed R5 should have reviewed R5's care plan and would have known there was no care plan for falls. LPN-B could not recall any fall interventions in place for R5. R4 R4's MDS dated 06/29/26 indicated intact cognition, dependence upon staff for toileting hygiene, activities of daily living (ADL), and occasional incontinence of bowel. R4's diagnoses included dementia, chronic respiratory failure, diabetes, and obesity. R4's care plan indicated the following: 4/21/26- assistance of two staff with care related to history of physical outburst with staff and / or accusations of staff not attempting cares, but the NA-A provided care alone 6/30/26- indicated incontinence of bowel with interventions to provide incontinence care and change the incontinence brief as needed after incontinence episodes R4's call light log indicated R4 activated his call light on 7/6/26 at 12:15 p.m., it was de-activated at 12:20 p.m., re-activated at 12:30 p.m. and de-activated again at 12:42 p.m.	20565	Continued from page 3 On July 24th, the director of nursing or designee will ensure that all care plans for residents at risk of falls are updated to include necessary interventions to promote resident safety and well-being. On 7/24/2026 skin check order sets were reviewed and edited to promote separate documentation of skin check completion and bathing task. Education and Prevention Measures: On 7/13/2026, the Director of Nursing implemented comprehensive training for nursing staff focused on fall risk evaluations, post-fall evaluations, order sets for post-fall monitoring, and immediate intervention implementation. Additionally, staff received education on the importance of care plan implementation, adherence to care plans, and the care planning process, including necessary updates. Training on skin check procedures, including routine schedules and compliance, was also completed. To prevent future deficiencies, the post-fall protocol was reviewed on 7/13/2026 to ensure it aligns with best practices and skin assessment protocol was reviewed. An audit of all resident care plans has been completed to confirm that fall risk factors and skin assessments are adequately addressed. Ongoing Monitoring Plan: To address the concerns identified during the survey, the Director of Nursing or a designated nurse manager will conduct ongoing audits of the comprehensive care plans to ensure they address all identified risk factors and interventions. Audits will be conducted daily to monitor the implementation of fall processes, weekly skin checks, and the implementation of care plans, including fall interventions. Audits of those requiring two staff for assistance will be audited 3x/weekly. These audits will continue until 100% compliance has been met consistently for four weeks consistently. Findings will be reviewed at the QAPI/Quality Assurance meeting on August 24th, 2026 and thereafter per the facility's QAPI review schedule to ensure continuous improvement and compliance.	07/25/2026

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20565	Continued from page 4 During an interview on 7/8/26 at 9:18 a.m., R4 stated on 7/6/26 he activated his call light around lunchtime. The nursing assistant (NA)-A responded, turned off his call light, and stated she was passing trays but was almost done and would come back. R4 stated he told the NA-A he had a bowel movement and was sitting in it. R4 stated the NA-A did not return, so he reactivated his call light and NA-B answered his light but declined to help him because R4 was not assigned to NA-B. R4 stated the NA-B told him he would have to wait until the NA-A returned from break about an hour later. During an interview on 7/8/26 at 9:42 a.m., NA-A stated R4 asked her to change his incontinence brief on 7/6/26, when she was passing lunch trays. NA-A told R4 she would return to help him as soon as she was done passing trays, and only had a few left. When NA-A walked by R4's room, R4 was eating, so NA-A told her team she was going on break and left. NA-A did not tell other staff R4 needed to be changed or telling R4 she was going on break. NA-A stated she was told when she returned from break, R4 reactivated his call light while she was gone, another NA answered the light and refused to change him. NA-A stated she told registered nurse (RN)-B that day about the other NA refusing to change R4. NA-A acknowledged she had not asked R4 if he was ready to be changed before she went on break, and RN-B asked her to change R4 before she went on break, but she did not. NA-A acknowledged she changed R4 herself, without the assistance of other staff as the care plan directed. During an interview on 7/8/26 at 9:50 a.m., RN-B stated on 7/6/26 before lunch time, she informed NA-A R4's call light was on. R4 needed to be changed before lunch and before NA-A took her break. RN-B stated R4 informed her on 7/6/26, a NA answered his light but then would not change him because R4 was not assigned to that NA that day. R4 did not identify the NA to the RN-B. The RN-B stated if an NA answered R4's call light, and R4 stated he needed to be changed, the NA should have performed the task when requested. RN-B stated she observed the NA-A changing R4 after the NA-A returned from break, around 12:15 p.m., and the NA-A did not have a second staff assisting as required. During an interview on 7/8/26 at 12:12 p.m., RN-C stated he did rounds when he arrived to work on 7/8/26 around 11:00 a.m., R4 told him about the incident in which NA-B refused to change him and NA-A didn't return to change him when she said she would. If RN-B asked NA-A to change R4 before	20565		07/25/2026

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20565	Continued from page 5 going on break, she should have. R6 R6's admission MDS dated 6/29/26, indicated intact cognition, risk of developing pressure ulcers (PU), two venous or arterial ulcers and moisture associated skin damage present. R6's diagnoses included malnutrition, lung disease, cellulitis (bacterial skin infection) of the right lower limb, and lymphedema (abnormal tissue swelling due to a buildup of protein-rich lymph fluid (clear, watery fluid that leaks out of blood vessels into the body's tissues). R6's provider orders indicated the following: 6/26/26 at 7:00 a.m., weekly shower or bath, complete skin check assessment, on day shift, every Friday. 7/8/26 at 3:00 p.m., Please complete skin check today. 7/8/26 at 11:30 a.m., skin check not completed, complete today (indicated the scheduled assessment had been missed) R6's July 2026 Treatment Administration record indicated on 7/3/26, R6's weekly bath and skin check were not performed as ordered and was not performed as ordered on 7/8/26. R6's wound care progress note dated 7/5/26 at 1:08 p.m., indicated wound care was performed for bilateral leg wounds. The progress note lacked indication of assessment of other skin areas. R6's care plan dated 7/2/26, indicated potential impairment to skin integrity related to chronic lymphedema with acute infection of venous stasis ulcers, obesity, incontinence, malnutrition, dependence upon staff for transfers, and medication use with interventions for daily wound monitoring dated 7/2/26, and weekly skin inspections and as needed (PRN) dated 7/2/26. R7 R7's annual MDS dated 6/16/26, indicated moderate cognitive impairment, risk of developing PU, and skin tears. R7's diagnoses included heart failure, diabetes, and edema (swelling caused by excess fluid trapped in the body's tissues). R7's care plan dated 9/22/25, indicated a potential	20565		07/25/2026

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20565	Continued from page 6 or actual impairment to skin integrity related to mobility, incontinence, oxygen dependence, and a biliary drain in the right upper quadrant (medical tube inserted through the skin of the upper right abdomen to relieve a blockage or leakage in the bile duct – tubes that carry bile from the liver and gall bladder into the small intestine), with an intervention for a skin inspection weekly and PRN dated 9/22/25. R7's provider orders dated 3/28/26, indicated perform a weekly shower and skin check. Further information about refusals must be documented in the progress notes with details about reapproaches. R7's July 2026 treatment administration record (TAR) indicated perform weekly shower and skin check every Saturday. The TAR lacked evidence that the shower or skin check was performed and indicated R7 refused some type of care, but did not identity which care. R7's progress notes dated 7/4/26 at 10:00 p.m., indicated the shower was refused, but lacked mention of whether the skin check was still offered, performed, or refused. The progress lacked indication staff reapproached or offered the shower or skin check at a later time or date. During an interview on 7/8/26 at 3:01 p.m., the director of nursing (DON) stated whoever answered the call light was responsible for changing the resident; R4 could not care for himself and required care in pairs because of prior allegations of staff not providing care. The DON stated the skin checks were not completed as ordered for R6 and R7 during the week of 6/28/26 and was not completed for R6 on 7/8/26. The DON did not know why these skin checks were not completed. During an interview on 7/9/26 at 3:19 p.m., the licensed practical nurse (LPN)-A stated the nurses were supposed to perform weekly skin checks on each resident to ensure staff didn't miss new bruises, injuries, or wounds. During an interview on 7/9/26 at 4:06 p.m., the LPN-B stated each resident required weekly skin checks to check for bruises, open areas, or unknown issues so nurses can follow up, notify the providers, and make a care plan to care for the new skin issue. The skin checks were performed weekly after the bath, and if the resident refused the skin check, staff should document it. The Care Planning – Resident Participation policy dated 4/1/26 indicated the care planning process	20565		07/25/2026

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20565	Continued from page 7 included an assessment of a resident's strengths and needs. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are developed and implemented for residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director or designee could review each resident's diagnosis to ensure a care plan with interventions is in place to support the care of the resident. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	20565		07/25/2026