Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 16, 2025

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

RE: CCN: 245235
Cycle Start Date: April 30, 2025

Dear Administrator:

On June 11, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 16, 2025

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

Re: Reinspection Results
Event ID: 52YT12

Dear Administrator:

On June 11, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 30, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any 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
May 13, 2025

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

RE: CCN: 245235
Cycle Start Date: April 30, 2025

Dear Administrator:

On April 30, 2025, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 30, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 30, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2025

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

Re: State Nursing Home Licensing Orders
Event ID: 52YT11

Dear Administrator:

The above facility was surveyed on April 28, 2025 through April 30, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING ______ B. WING ______	C 04/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/28/25 through 4/30/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was NOT in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H52352949C (MN112236) and a deficiency was issued at F558 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 substantial compliance with the regulations has been attained.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure call lights were within reach and accessible for 1 of 3 residents	F 558	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	6/4/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/19/2025

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

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F 558

Continued From page 1

(R1), who was dependent on staff for care.

Findings include:

R1's care plan revised 12/23/24, identified a focus that R1 had potential for/actual communication problem with difficulty expressing ideas, understanding others related to speech is clear. Intervention identified to ensure/provide a safe environment: Call light in reach, adequate low glare light, bed at appropriate height and wheels locked, and avoid isolation.

R1's quarterly Minimum Data Set (MDS) dated 3/2/25, identified R1 had diagnoses of encounter for palliative care, anxiety, depression, and chronic pain syndrome. R1's cognition was moderately impaired and required substantial to maximum assist for toileting hygiene, dressing and bed mobility.

During an observation and interview on 4/28/25 at 12:15 p.m., R1's room on the third floor was the last room on the left at the end of the hallway furthest from the nursing station. R1 was heard right just outside her room yelling softly but urgently for help. R1 was lying in bed on her back with the head of the bed elevated approximately 30 degrees, behind R1's head was a pink body pillow where R1's soft touch call light was draped over the back of the pillow on R1's right side above her head and has a contracted left hand. R1 stated she needed help because her shoulders were hurting and was unable to reach her call light, and stated she did not know where it was. R1 was shown the call light, but she was unable to reach it and asked the button to be pushed for assistance. At 12:20 p.m., Nursing assistant (NA)-A and NA-B walked in the room

F 558

as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:

1. Resident R1 call light was immediately audited and within reach. Preferences reviewed and prefers to have call light near her with a soft touch call activator while in room. Care plan reviewed and current.

2. All residents have the potential to be affected. All nursing staff were provided immediate education on call light accessibility starting 4/29/2025. All residents audited 4/30/2025 for proper call light placements and accessibility. All residents have access to utilize call light per preferences.

3. Education to be provided to all staff on call light placement and accessibility.

4. The Director of Nursing or designee will audit 20 rooms 2 times weekly for 2 weeks during random shifts and then 10 rooms 2 times weekly for 4 weeks during random shifts to obtain 100% compliance x4 weeks. Audit results will be reviewed at the monthly QAPI committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, MN 55125**

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F 558		F 558		

Continued From page 2

and informed R1 they would get her up in the chair so she could eat lunch. At 12:22 p.m. Licensed practical nurse (LPN)-A administered R1's scheduled pain medications. NA-A, NA-B and LPN-A all stated that R1's call light was not within her reach and should be. NA-B stated she forgot to put the call light in place for R1 when she was last in R1's room about a half hour ago. NA-A and NA-B both stated R1 does use her call light to ask for help and the call light should be placed in reach of R1's right hand because her left hand was contracted.

During an interview on 4/28/25 at 12:59 p.m., LPN-A indicated she was R1's nurse for the shift and that R1's call light should always be in reach. LPN-A stated R1 had anxiety and recently did not like being left alone.

During an interview on 4/28/25 at 2:11 p.m., director of nursing (DON) stated it would be an expectation that all residents that are dependent on staff for ADL's that their call light should be within reach at all times.

Facility policy, Accessible Call light, dated 5/1/25, identified the purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. 1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. 2. All residents will be educated on how to call for help by using the resident call system. 3. Each resident will be evaluated for unique needs and preferences to

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F 558	Continued From page 3 determine any special accommodations that may be needed in order for the resident to utilize the call system. 4. Special accommodations will be identified on the resident's person-centered plan of care and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.) 5. Staff will ensure the call light is within reach of resident and secured, as needed.	F 558		
F 880 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: §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	F 880		6/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 4 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 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 observation, interview and document	F 880	1.) R1 EBP room set up and signage	

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F 880	Continued From page 5 review the facility failed to ensure Enhanced Barrier Precautions (EBP)- (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities,) were implemented or followed for management of a non-pressure skin wound to reduce the risk of infection to others for 1 of 1 resident (R1). Further the facility failed to implement hand hygiene for 1 of 1 resident (R1) observed during incontinence care and transfer. Findings included: R1's care plan revised 1/28/25, identified a focus that R1 had a disease/condition requiring precautions-wounds with drainage, history of Methicillin Resistant Staphylococcus Aureus (MRSA)-(caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections). Interventions dated 8/8/24, identified to bag and transport used linen according to facility protocol, preventing skin exposure or contamination, educate resident/family on appropriate use of antibiotics, stress importance of finishing all antibiotics, give antibiotic therapy as ordered, observe for and report and side effects to medical practitioner, isolation procedure according to the facility protocol, post sign on door, and contact isolation. Revision on 1/28/25, identified R1 required EBP precautions. The care plan does not identify to use EBP with high-risk activities or what the high-risk activities include. R1's quarterly Minimum Data Set (MDS) dated 3/2/25, identified R1's cognition was moderately impaired and had diagnoses of peripheral	F 880	audited and remains appropriate. 2.) All residents have the potential to be affected. All nursing staff were given immediate education on enhanced barrier precautions (EBP) and handwashing starting on 4/29/2025. 3.) Nursing staff will be educated on EBP and hand washing with PPE competency and handwashing competency completion. 4.) The director of nursing or designee to audit EBP use on 10 occasions, 3 times weekly, until 2 weeks of 90% compliance or greater than on 5 occasions, 2 times weekly until 90% compliance or greater is obtained. Results of audit to be reviewed at the monthly QAPI committee. The director of nursing or designee to audit handwashing during high contact cares 2 times weekly on 10 occasions per week during random shifts/units until less than 10% missed opportunities are obtained of hand hygiene than weekly on 5 occasions per week during	

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F 880	Continued From page 6	F 880		

vascular disease (PVD)- (a disease that involves reduced blood flow to limbs, often due to narrowed or blocked vessels, and can lead to symptoms like pain, numbness, and slow wound healing) and unspecified wound of lower left and right leg.

R1's Treatment Administration Record (TAR) dated 4/2/25, identified R1's left leg wounds to clean wound with wound cleanser apply xeroform (petrolatum-based gauze dressing) to open areas only, apply ABD (highly absorbent pad used for wound care) then gauze wrap, change dressing every shift.

R1's Medical Doctor (MD) note visit dated 4/14/25, identified R1's reason for a visit was a recheck. Assessment identified R1 had a history of wounds non-healing to bilateral lower extremities, history of recurrent cellulitis to left lower extremity requiring hospitalization/wound infection, history of MRSA bacteremia with open area on both legs, and bilateral venous stasis ulcers non-healing. History identified R1 was on hospice for PVD and open wounds. R1 has had at least 20 admissions related to this with multiple re-hospitalization due to cellulitis infected wounds and felt this was a noncurative condition. Amputation of R1's bilateral lower extremity was recommended but R1 refused. The hospital recommended hospice and feels that antibiotics would no longer be justified. Physical exam revealed R1's feet are cold with minimal edema noted on legs with venous stasis dermatitis- (a skin condition caused by poor circulation in the legs, leading to blood pooling and inflammation). Open areas on both legs with no dressing.

During an observation and interview on 3/18/25 at

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	245235	A. BUILDING ______ B. WING ______	C 04/30/2025

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

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F 880	Continued From page 7 12:15 p.m., upon entrance to the left of R1's door was an orange paper sign taped to the wall. There were two "STOP" signs noted on the floor. Signage read: "ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, changing linens, Providing Hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheotomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person." The sign also had pictures of hand cleanser, gloves, and gown. There was no personal protective equipment (PPE) cart observed outside of R1's room. R1 was lying in bed and a dressing dated 4/28/25 was noted to R1's left lower leg. Nursing assistant (NA)-A and NA-B walked into R1's room without doing hand hygiene, and did not utilize masks or a gown. NA-A and NA-B applied gloves and performed incontinence care for R1. After removing R1's brief and providing peri-care, NA-A changed gloves without hand hygiene, applied a new pair of gloves. NA-B was assisting with rolling R1 in bed and kept her gloves on. NA-A and NA-B transferred R1 from the bed to her wheelchair using a full body mechanical lift. NA-A removed her gloves without doing hand hygiene and wheeled R1 to the dining room for lunch and placed a protective clothing covering on R1's chest. NA-B removed gloves and performed hand hygiene and carried R1's covered lunch tray that had been sitting on her bedside table to the dining room and heated her food up in the microwave. During an interview at 12:26 p.m. NA-A and NA-B stated they were not	F 880		

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aware that they needed to use EBP during personal cares for R1. Both stated when a resident was supposed to be on EBP precautions the DON would put a PPE cart outside of the resident's room. Both verified the signage was outside of R1's door and no PPE cart was observed. Both staff stated R1 had a wound on her left lower leg. NA-A and NA-B stated all their PPE was disposable and would just dispose of the PPE in the resident's garbage can in the resident's room. NA-A stated she did not wash her hands after changing from soiled to clean gloves or upon entering and exiting the room. NA-B stated she did not perform hand hygiene upon entrance to the room.

On 4/28/25 at 12:59 p.m., licensed practical nurse (LPN)-A stated she was R1's nurse for the shift and staff should follow EBP precautions for all personal care, including toileting, incontinence care, and transfers, due to R1's wounds and MRSA history. LPN-A was unaware that a PPE cart was not available outside R1's room. She also emphasized that hand hygiene should be practiced upon entering and exiting the room, as well as between dirty and clean glove changes.

During an interview on 4/28/25 at 2:11 p.m., director of nursing (DON stated it would be an expectation for all staff to follow facility policy and procedure of EBP and hand hygiene. DON verified R1 was on EBP precautions due to chronic venous wounds and history of MRSA, this would include to use mask, gown and gloves with any personal cares to include toileting/incontinence care. DPON further stated hand hygiene upon entrance and exit of resident room, along with hand hygiene between glove changes would be the expectation to help prevent

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the risk of infections.

Facility policy PPE selection and Use, reviewed 9/2023, identified Purpose: Improve personal safety with the appropriate use of Personal Protective Equipment. GUIDELINE: Personal Protective Equipment (PPE) is clothing or equipment worn by an employee for protection against infectious materials (OSHA). Enhanced barrier precautions used for any resident with an infection or colonization of a novel or MDRO when contact precautions do not apply. These precautions are intended for long term use and Isolation is NOT required. Enhanced Barrier Precautions may apply to wounds or indwelling medical devices (central line, urinary catheter, feeding tube, tracheotomy) regardless of MDRO colonization. These precautions are used during high contact resident care activities such as dressing, bathing, transfers, hygiene, incontinence care, device or wound care.

Facility policy, Hand Hygiene, revised 7/21, identified Purpose: Proper hand washing techniques should be used to protect the spread of infection. Cleaning your hands reduces the spread of potentially deadly germs to the resident and reduces the risk of healthcare provider colonization or infection caused by germs acquired from the resident. Hand hygiene may occur multiple times during a single care episode. Use alcohol based hand sanitizer immediately before touching a patient..before moving from a soiled body site to a clean body site on same resident/patient, after touching a resident/patient or the resident's/patient's immediate environment, after contact with blood, body fluids or contaminated surfaces and immediately before putting on gloves and after glove removal.

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Minnesota Department of Health

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2 000	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 4/28/25 through 4/30/25, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed: H52352949C (MN112236) with a licensing order issued at 1390. 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	2 000		

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2 000	Continued From page 2 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.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		6/4/25

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21390	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure Enhanced Barrier Precautions (EBP)- (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities,) were implemented or followed for management of a non-pressure skin wound to reduce the risk of infection to others for 1 of 1 resident (R1). Further the facility failed to implement hand hygiene for 1 of 1 resident (R1) observed during incontinence care and transfer. Findings included: R1's care plan revised 1/28/25, identified a focus that R1 had a disease/condition requiring precautions-wounds with drainage, history of Methicillin Resistant Staphylococcus Aureus (MRSA)-(caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections). Interventions dated 8/8/24, identified to bag and transport used linen according to facility protocol, preventing skin exposure or contamination, educate resident/family on appropriate use of antibiotics, stress importance of finishing all antibiotics, give antibiotic therapy as ordered, observe for and report and side effects to medical practitioner, isolation procedure according to the facility protocol, post sign on door, and contact isolation. Revision on 1/28/25, identified R1 required EBP precautions. The care plan does not identify to use EBP with high-risk activities or what the high-risk activities include.	21390	1.) R1 EBP room set up and signage audited and remains appropriate. 2.) All residents have the potential to be affected. All nursing staff were given immediate education on enhanced barrier precautions (EBP) and handwashing starting on 4/29/2025. 3.) Nursing staff will be educated on EBP and hand washing with PPE competency and handwashing competency completion. 4.) The director of nursing or designee to audit EBP use on 10 occasions, 3 times weekly, until 2 weeks of 90% compliance or greater than on 5 occasions, 2 times weekly until 90% compliance or greater is obtained. Results of audit to be reviewed at the monthly QAPI committee. The director of nursing or designee to audit handwashing during high contact cares 2 times weekly on 10 occasions per week during random shifts/units until less than 10% missed opportunities are obtained of hand hygiene than weekly on 5 occasions per week during	

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R1's quarterly Minimum Data Set (MDS) dated 3/2/25, identified R1's cognition was moderately impaired and had diagnoses of peripheral vascular disease (PVD)- (a disease that involves reduced blood flow to limbs, often due to narrowed or blocked vessels, and can lead to symptoms like pain, numbness, and slow wound healing) and unspecified wound of lower left and right leg.

R1's Treatment Administration Record (TAR) dated 4/2/25, identified R1's left leg wounds to clean wound with wound cleanser apply xeroform (petrolatum-based gauze dressing) to open areas only, apply ABD (highly absorbent pad used for wound care) then gauze wrap, change dressing every shift.

R1's Medical Doctor (MD) note visit dated 4/14/25, identified R1's reason for a visit was a recheck. Assessment identified R1 had a history of wounds non-healing to bilateral lower extremities, history of recurrent cellulitis to left lower extremity requiring hospitalization/wound infection, history of MRSA bacteremia with open area on both legs, and bilateral venous stasis ulcers non-healing. History identified R1 was on hospice for PVD and open wounds. R1 has had at least 20 admissions related to this with multiple re-hospitalization due to cellulitis infected wounds and felt this was a noncurative condition. Amputation of R1's bilateral lower extremity was recommended but R1 refused. The hospital recommended hospice and feels that antibiotics would no longer be justified. Physical exam revealed R1's feet are cold with minimal edema noted on legs with venous stasis dermatitis- (a skin condition caused by poor circulation in the legs, leading to blood pooling and inflammation). Open areas on both legs with no dressing.

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21390	Continued From page 5 During an observation and interview on 3/18/25 at 12:15 p.m., upon entrance to the left of R1's door was an orange paper sign taped to the wall. There were two "STOP" signs noted on the floor. Signage read: "ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, changing linens, Providing Hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheotomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person." The sign also had pictures of hand cleanser, gloves, and gown. There was no personal protective equipment (PPE) cart observed outside of R1's room. R1 was lying in bed and a dressing dated 4/28/25 was noted to R1's left lower leg. Nursing assistant (NA)-A and NA-B walked into R1's room without doing hand hygiene, and did not utilize masks or a gown. NA-A and NA-B applied gloves and performed incontinence care for R1. After removing R1's brief and providing peri-care, NA-A changed gloves without hand hygiene, applied a new pair of gloves. NA-B was assisting with rolling R1 in bed and kept her gloves on. NA-A and NA-B transferred R1 from the bed to her wheelchair using a full body mechanical lift. NA-A removed her gloves without doing hand hygiene and wheeled R1 to the dining room for lunch and placed a protective clothing covering on R1's chest. NA-B removed gloves and performed hand hygiene and carried R1's covered lunch tray that had been sitting on her bedside table to the dining room and heated her food up in the microwave. During an interview at	21390		

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21390	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policy and procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE to wear. They could also do environmental rounds and audits, and re-education anytime EBP are placed. The DON, ICP or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		