Electronically delivered
November 6, 2021

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

RE: CCN: 245320
Cycle Start Date: October 20, 2021

Dear Administrator:

On October 20, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 January 20, 2022 (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 April 20, 2022 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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November 6, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: D8Q611

Dear Administrator:

The above facility was surveyed on October 19, 2021 through October 20, 2021 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00829	A. BUILDING: _____ B. WING _____	C 10/20/2021

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

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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 10/19/21, through 10/20/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000	*****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has	

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2 000	Continued From page 1 when they will be completed. The following complaint were found to be SUBSTANTIATED: -H5320066C (MN77579 & MN77606), with no licensing orders issued. However, as a result of the investigation licensing orders were issued at 0830. The following complaints were found to be UNSUBSTANTIATED: -H5320064C (MN77152) -H5320065C (MN77427) -H5320067C (MN774400) however, as a result of the investigation with a licensing order issued at 1925. 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 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	2 000	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:	

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2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by:	2 830		11/15/21

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2 830	Continued From page 3 Based on observation, interview, and document review, the facility failed to implement interventions as directed by the care plan for 1 of 1 resident (R5) who rolled out of bed and to the floor and sustained an abrasion and pain reviewed for falls. Findings include: R5's annual Minimum Data Set (MDS) dated 10/19/21, indicated R5's diagnosis included quadriplegia, Multiple Sclerosis (MS), and anxiety. The MDS indicated R5 was cognitively intact and required two staff physical assistance for bed mobility, transfers, and toilet use; R5 had a functional limitation in range motion on both upper and lower extremities; R5 did not reject cares and R5 had a fall with injury since the previous assessment. R5's mobility care plan dated dated 4/25/21, identified resident had limited physical mobility related to MS and was at risk for falls. The care plan directed staff for bed mobility resident required two staff assistance to reposition and turn in bed and was totally dependent on staff for repositioning and turning. R5's activities of daily living (ADL)dated 8/9/21, identified R5 had an self care performance deficit related to MS, quadriplegia, neurogenic bladder, bed and wheelchair dependence. The care plan indicated for bed mobility R5 was totally dependent on staff for repositioning and turning and requires 2 staff assistance. R5's falls Care Area Assessment (CAA) dated 10/19/21, indicated R5 was at risk for falls and was dependent on staff for all assistance with ADL's related to MS and being quadriplegic.	2 830	completed	

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2 830	Continued From page 4 R5's nursing assistant task sheet dated 10/19/21, indicated R5 required assistance of two staff for bed mobility which included turning and repositioning. R5 Fall Incident Report dated 10/7/21, indicated "NAR told writer resident rolled off the bed while she was attempting to change her bed sheets. Writer found resident lying on the floor next to the bed face up. Resident denied hitting head and stated a small pain in the right shoulder from a previous fall." The incident report indicated R5 had sustained an abrasion to the right front knee and the immediate action taken included checking the vital signs which were stable and R5 was assisted with a mechanical lift back to the bed. A general progress note dated 10/12/21, at 2:31 p.m. indicated "Therapy reported to nursing staff that resident's pain level and swelling in right arm has worsened. They did not move that arm in therapy session due to this observation. Information reported to nurse practitioner [NP] on 10/11/21. NP had seen resident, replied on 10/12/21 that we could proceed with shoulder and arm X-ray. After discussion with rehab order was processed." During interview on 10/20/21, at 8:37 a.m. R5 stated at the time of the incident nursing assistant (NA)-A was standing on the right side of the bed. "I rolled out of bed to the window side so fast. She was alone in the room at the time this happened." R5 further stated following the incident she had scrapped her knee and her arm and shoulder hurt and hip was bruised and she was still sore on the knee and arm since the incident and was using pain medication for pain	2 830		

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2 830	Continued From page 5 management. During interview on 10/21/21, at 8:53 a.m. registered nurse (RN)-B stated prior to the incident therapy had been working with R5 but after the incident when R5 rolled out of bed therapy staff had noticed more swelling and pain in the shoulder and that was why she had updated the nurse practitioner and had gotten an order to do a x-ray which was negative for fractures. RN-B further stated according to R5 the pain was well controlled. During interview on 10/19/21, at 1:24 p.m. the director of nursing (DON) stated when the incident occurred the nurse stated NA-A was trying to reposition resident and in the process of trying to position the sheets, R5 had rolled out of bed. The DON stated at the time of the incident there was only one staff in the room and that was NA-A who was from the agency "pool aide." The DON stated NA-A had approached him that shift upset that the other aides working at the unit were not assisting her. The DON stated when he had followed up with the aides he was informed that when they had offered assistance NA-A had said "No." The DON stated when R5 rolled out of bed the management team had questioned how it had happened because R5 had no prior incidents as R5 was a quadriplegic and required total staff assistance. The DON reviewed R5's care plan and MDS and acknowledged R5 required total physical assistance of two staff with bed mobility which included turning and repositioning. The DON stated he expected staff to follow the plan of care when providing cares and this included the agency staff. The facility Fall Risk and Prevention Guidelines policy revised February 2019, indicated the facility	2 830		

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2 830	Continued From page 6 was to ensure adequate interventions were in place to decrease, limit and prevent resident falls and was to ensure resident safety while maintaining their dignity and highest practical level of abilities. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's	21925		11/15/21

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21925	Continued From page 7 control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure written transfer notices were provided to the resident or resident representative and to the Long-Term Care Ombudsman following a facility-initiated transfer to the hospital for 1 of 1 resident (R) reviewed for hospitalization. This had the potential to affect all 57 residents residing in the facility. Findings include: R4's diagnoses included muscle weakness, Wernicke's encephalopathy, and alcohol abuse obtained from the significant Minimum Data Set (MDS) dated 9/18/21. In addition, the MDS identified R4 had intact cognition and had indicated it was "Very Important" to involve family or a close friend in discussions about his health. During review of the medical record, it was reveled R4 had a discharge return not anticipated MDS dated 10/5/21, to an acute hospital however, the nursing notes lacked documentation when and why R4 had been transferred to the hospital. During review of a general note dated 10/8/21, at	21925	corrected	

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21925	Continued From page 8 12:45 p.m. it was revealed the writer and director of nursing (DON) spoke with R4's family member "and informed her at this time we would not be able to accept him back to the facility. [family member] understood and will notify social services when she will be able to pick up his belongings next week." During interview on 10/20/21, at 9:05 a.m. the DON stated on 10/5/21, R4 had been sent to the hospital after the speech therapist had reported R4 was making suicidal ideation's and at the time razors had been confiscated from the room. The DON stated he did not know if a written transfer notices were provided to the resident or resident representative and to the Ombudsman following a facility-initiated transfer. The DON called the director of social service on the telephone to ask. -At 9:09 a.m. DSS stated she had not given the written notice and did not know there was a regulation for notices to be provided. The DSS also verified the Ombudsman had not been informed of the facility-initiated hospital transfer and R4 not being allowed to return to the facility. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 10/20/2021

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E 000	Initial Comments On 10/19/21, through 10/20/21, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was found to be IN compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/19/21, through 10/20/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint were found to be SUBSTANTIATED: H5320066C (MN77579 & MN77606), with a deficiency cited at F600. However, as a result of the investigation additional deficiencies were identified at F609, F610 and F689. The following complaints were found to be UNSUBSTANTIATED with no deficiency cited. H5320064C (MN77152) H5320065C (MN77427) H5320067C (MN774400) however, as a result of the investigation additional deficiencies were identified at F623 & F625.	F 000		

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

Electronically Signed | 11/15/2021

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F 000	Continued From page 1 In addition, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was found to be IN compliance. 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.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		11/15/21

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F 600	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents remained free from abuse for 1 of 3 residents (R3) who alleged physical abuse when a staff member hit her cheeks resulting in bruising reviewed for abuse. Findings include: R3's annual Minimal Data Set (MDS) dated 9/20/21, indicated R3's diagnoses included dementia, hemiplegia/hemiparesis and was cognitively intact. Further review of MDS, indicated R1 required total assistance from two staff members for bed mobility, transfers, dressing and toileting. R3's care plan printed 10/19/21, indicated R1 had an deficit in activities of daily living (ADLs) self-care performance related to diagnoses of hemiplegia, traumatic brain injury, seizures and personality disorder. Further review of R3's care plan, indicated R3 had a communication problem related to unclear speech at times but was able to make her needs known. In addition, R3's care plan identified R3 as a vulnerable adult related to nursing home admission, poor cognition/dementia, total assistance with mobility, impaired speech and yelling out behaviors. R1's progress note dated 10/11/21, at 11:10 p.m. indicated "Resident PCA [personal care assistant] informed writer about bruise on resident left lower face. The PCA further explained, she saw the bruise on Sunday 10/10/21, but the nurses were so busy that she could not report. Writer saw the bruise and ask resident what happened, resident states "An aid from the pool got angry and hit me"	F 600	F 600 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F600, Freedom from Abuse, Neglect, and Exploitation. Woodlyn Heights Senior Living corrected the deficiency by immediately making sure R3 and all like residents were safe and suspended alleged employees. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 10/19/2021 or prior to their next scheduled shift, on the vulnerable adult policy by David Fatokun, Assistant DNS. The DNS and/or designee will audit all progress notes and incident reports in	

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F 600	Continued From page 3 Writer asked when that happened, but resident said couple days back, but she can't remember the exact day that it happened. Writer assessed pain on the area and resident rated a pain level of 2 on a scale of 0-10. The bruise measures 2.5 centimeters width and 3-centimeter length." Further review of R1's progress notes lack evidence of when the bruising first appeared. On 10/19/21, at 9:05 a.m. R3 stated "she squeezed my cheeks, used just one hand and got a bruise on the left side. I wanted more ice in my cup and she said I had enough ice and squeezed my cheeks." On 10/19/21, at 12:17 registered nurse (RN)-A indicated R3 required assistance from staff with all ADLs. Further, RN-A indicated R3 had behaviors which consisted of yelling and not having patience when she puts call light on. RN-A indicated on 10/11/21, R3 reported "an aid from the pool hit her on the jaw". In addition, RN-A indicated since the incident there has been no additional training provided on abuse or reporting. Review of facility investigation report to the SA dated 10/18/21, indicated both AP's were removed from schedule pending investigation, other facility staff were interviewed for potential witnesses, and resident's on the unit were interviewed and no additional concerns were noted. On 10/19/21, at 12:27 p.m. interview with both administrator and consultant indicated following the allegation of abuse staff education had not been initiated until 10/19/21. On 10/19/21, at 2:04 p.m. director of nursing	F 600	point click care daily for 4 weeks, weekly for 4 weeks, and then randomly to ensure compliance. 3. As part of Woodlyn Heights Senior Living's ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process.	

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F 600	Continued From page 4	F 600		

(DON) indicated R3 required assistance with all ADLs and was care planned to display yelling behaviors. Further, DON indicated R3 was cognitively intact and not known to make accusations regarding staff. DON stated "though the investigation it was not witnessed. I think we pinpointed the person and [R3] is cognitive level is 15 on the BIMS if she said someone hit her she knows what's going on and if there is evidence that it points to that I would say yes its substantiated for abuse." In addition, DON indicated he was made aware of the allegation on 10/12/21, and education for staff on abuse was started on 10/19/21.

On 10/20/21, at 8:26 a.m. RN-B indicated R3 was "dependent" on staff for most ADLs. RN-B indicated while assisting R3 with cares after the allegation was reported, RN-B asked if a staff member "pinched your cheeks" and R3 stated yes and then RN-B asked, "if it was done playfully of harshly?" and R3 replied "harshly". In addition, RN-B indicated R3 is alert and has not had a history of making accusations regarding staff.

On 10/20/21, at 8:44 a.m. Administrator indicated she was notified of the allegation on 10/12/21 and education to staff regarding abuse began on 10/19/21. Administrator indicated the allegation was not witnessed and "no one admitted to the incident" so the allegation was not substantiated. In addition, Administrator indicated R3 does not have a history of making accusations regarding staff.

Review of facility policy titled VA Policy reviewed 01/20, indicated "we believe all adult residents living or receiving services in Woodlyn Heights Healthcare Center are vulnerable and come

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F 600	Continued From page 5 under the protection of the VAA and it is our policy to ensure the resident s free from abuse, neglect, mistreatment, misappropriate of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms and injuries of unknown source sustained by a vulnerable adult that is not reasonably explained immediately (as soon as possible)." Further review of policy, defined abuse as "the will infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology." In addition, the policy defines physical abuse as "includes, but is not limited to hitting, slapping, pinching and kicking."	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		11/15/21

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F 609	Continued From page 6 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of employee to resident physical abuse were reported timely, within two hours, to the State Agency (SA) for 1 of 1 (R3) residents reviewed for timely reporting. Findings include: R3's annual Minimal Data Set (MDS) dated 9/20/21, indicated R3's diagnoses included dementia, hemiplegia/hemiparesis and was cognitively intact. Further review of MDS, indicated R1 required total assistance from two staff members for bed mobility, transfers, dressing and toileting. An incident report was submitted to the SA on 10/12/21, at 11:47 a.m. by the director of nursing (DON). The incident report identified an allegation of physical abuse resulting in a bruise of unknown origin. The date and time of the incident was identified on 10/9/21, at 12:00 a.m. The description of the incident was identified as "an aide from the pool got angry and hit me." Further	F 609	F 609 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 609, Reporting of Alleged Violations.	

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F 609	Continued From page 7 review of incident report indicated a full body assessment was completed, mental health status assessed, primary care physician was notified with no new orders given, and staff was suspended. R1's progress note dated 10/11/21, at 11:10 p.m. indicated "Resident PCA [personal care assistant] informed writer about bruise on resident left lower face. The PCA further explained, she saw the bruise on Sunday 10/10/21, but the nurses were so busy that she could not report. Writer saw the bruise and ask resident what happened, resident states "An aid from the pool got angry and hit me" Write asked when that happened but resident said couple days back, but she can't remember the exact day that it happened. Writer assessed pain on the area and resident rated a pain level of 2 on a scale of 0-10. The bruise measures 2.5 centimeters width and 3-centimeter length." Further review of R1's progress notes lack evidence of when the bruising occurred. Review of facility document titled Grievance Form dated 10/11/21, written by register nurse (RN)-A indicated "See attached" with a copy of the progress note 10/11/21 noted above. Further, facility document indicates nursing department is responsible for the investigation and assigned 10/12/21. On 10/19/21, at 9:05 a.m. R1 indicated last week in the afternoon an aid from the pool "squeezed my cheeks" when R1 requested more ice in her glass. Further, R1 indicated there was a bruise on both sides of her mouth both of which have resolved. R1 indicated she had reported it to a nurse after the incident occurred but was unsure of a date.	F 609	Woodlyn Heights Senior Living corrected the deficiency by educating David Fatokun, ADNS on the Federal Reporting Requirements and the vulnerable adult policy by Scott Sommers, Interim DNS on 10/18/2021. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 10/19/2021 or prior to their next scheduled shift, on the vulnerable adult policy by David Fatokun, Assistant DNS. The DNS and/or designee will audit all progress notes and incident reports in point click care daily for 4 weeks, weekly for 4 weeks, and then randomly to ensure compliance. 3. As part of Woodlyn Heights Senior Living□s ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community□s QA Process.	

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F 609	Continued From page 8	F 609		

On 10/19/21, at 12:17 p.m. RN-A indicated if a resident were to report an allegation of abuse, she was expected to report the allegation to her supervisor and DON within two hours. Further, RN-A indicated she also needs to write a report on the allegation. RN-A indicated on 10/11/21, she was R1's nurse and R1's PCA approached her and reported the bruise. When RN-A asked R1 what happened, R1 reported "an aid from the pool hit me in my jaw". After RN-A was notified of the abuse allegation, RN-A stated she reported the allegation to the assistant director of nursing (ADON) within two hours, which RN-A then was directed by ADON to "write a note and when he comes in, he would work on that." In addition, RN-A indicated since the incident, there has been no additional education provided regarding abuse and reporting.

On 10/19/21, at 1:56 p.m. ADON indicated he was made aware of the abuse allegation by RN-A on 10/11/21, "at nighttime" and then stated he would investigate it the following day but directed RN-A to "document what happened". In addition, ADON stated "I didn't get to see that situation until the following morning so that is when I saw the bruise. We didn't report within the two hours frame, but we did follow up on it the following morning." When asked about education on abuse and reporting, ADON stated "since the incident we are still working on the education piece to prevent it from happening again and what I should have done. I have not been educated fully enough on it."

On 10/19/21, at 2:04 p.m. DON indicated he was notified of the abuse allegation on 10/12/21, at 9:20 a.m. when he saw it on "shift report". Upon

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F 609	Continued From page 9	F 609		

notification, DON indicated he reported the allegation to the Administrator and Social Services (SS). DON confirmed abuse allegations were to be reported to the SA within two hours of "finding out about it". Further, DON indicated R1's allegation of abuse should have been reported on 10/11/21, when RN-A notified ADON and the process would have been then "to notify me". DON indicated abuse and reporting training for all staff was started on 10/17/21, with the original completion date of 10/30/21, however DON stated, "the resource center said we had to do it sooner".

On 10/20/21, at 8:44 a.m. Administrator indicated she was notified of R1's allegation of abuse on the morning of 10/12/21. Administrator indicated R1's PCA reported the allegation to staff on the evening of 10/11/21. Further, Administrator indicated staff were expected to report immediately and confirmed the allegation should have been reported on 10/11/21 within two hours of R1 reporting the allegation. In addition, Administrator indicated abuse and reporting training was initiated on 10/19/21 and "we are completing education upon staff coming on for their next shift. Education is provided to all staff and contracted staff as well."

Review of facility policy titled VA Policy revised 01/20, indicated "mandated reporters employed by Woodlyn Heights Healthcare Center or providing services in our facility shall report abuse, neglect, mistreatment, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraints and injuries of unknown source sustained by a vulnerable adult that is not reasonably explained immediately (as

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F 609	Continued From page 10 soon as possible) after the discovery of the incident." Further review of the policy, indicated "all alleged violations will be reported immediately but not later than 2 hours after forming the suspicion, if the alleged violation involves abuse OR serious bodily injury."	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		11/15/21

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 11	F 623		

be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 12 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure written transfer notices were provided to the resident or resident representative and to the Long-Term Care Ombudsman following a facility-initiated transfer to the hospital for 1 of 1 resident (R) reviewed for hospitalization. This had the potential to affect all 57 residents residing in the facility. Findings include: R4's diagnoses included muscle weakness, Wernicke's encephalopathy, and alcohol abuse	F 623	F 623 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for	

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F 623	Continued From page 13 obtained from the significant Minimum Data Set (MDS) dated 9/18/21. In addition, the MDS identified R4 had intact cognition and had indicated it was "Very Important" to involve family or a close friend in discussions about his health. During review of the medical record, it was reveled R4 had a discharge return not anticipated MDS dated 10/5/21, to an acute hospital however, the nursing notes lacked documentation when and why R4 had been transferred to the hospital. During review of a general note dated 10/8/21, at 12:45 p.m. it was revealed the writer and director of nursing (DON) spoke with R4's family member "and informed her at this time we would not be able to accept him back to the facility. [family member] understood and will notify social services when she will be able to pick up his belongings next week." During interview on 10/20/21, at 9:05 a.m. the DON stated on 10/5/21, R4 had been sent to the hospital after the speech therapist had reported R4 was making suicidal ideation's and at the time razors had been confiscated from the room. The DON stated he did not know if a written transfer notices were provided to the resident or resident representative and to the Ombudsman following a facility-initiated transfer. The DON called the director of social service on the telephone to ask. -At 9:09 a.m. DSS stated she had not given the written notice and did not know there was a regulation for notices to be provided. The DSS also verified the Ombudsman had not been informed of the facility-initiated hospital transfer and R4 not being allowed to return to the facility.	F 623	procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F623, Notice Requirements Before Transfer/Discharge. Woodlyn Heights Senior Living corrected the deficiency by implementing a Notice of Transfer or Discharge Process. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were re-educated on 11/12/2021 or prior to their next scheduled shift on the Notice of Transfer or Discharge Process by Scott Sommers, Interim DNS. The DNS and/or designee will audit all transfers or discharges two times per week for 4 weeks, weekly for 4 weeks, and then randomly to ensure substantial compliance. 3. As part of Woodlyn Heights Senior Living□s ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community□s QA Process.	

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F 625	Continued From page 14	F 625		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the resident or their representative, a bed hold notice for 1 of 1 residents (R4) reviewed for hospitalizations. Findings include:	F 625	F 625 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement	11/15/21

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F 625	Continued From page 15 R4's diagnoses included muscle weakness, Wernicke's encephalopathy, and alcohol abuse obtained from the significant Minimum Data Set (MDS) dated 9/18/21. In addition, the MDS identified R4 had intact cognition and had indicated it was "Very Important" to involve family or a close friend in discussions about his health. During review of the medical record, it was reveled R4 had a discharge return not anticipated MDS dated 10/5/21, to an acute hospital however, the nursing notes lacked documentation when and why R4 had been transferred to the hospital. In addition, R4's medical record lacked indication a bed hold notice was provided to R4 or their representative. During review of a general note dated 10/8/21, at 12:45 p.m. it was revealed the writer and director of nursing (DON) spoke with R4's family member "and informed her at this time we would not be able to accept him back to the facility. [family member] understood and will notify social services when she will be able to pick up his belongings next week." During interview on 10/20/21, at 9:05 a.m. the DON stated on 10/5/21, R4 had been sent to the hospital after the speech therapist had reported R4 was making suicidal ideation's and at the time razors had been confiscated from the room. The DON stated he had reviewed the medical record and acknowledged a bed hold notice had not been provided to R4 or the representative. The DON also stated during the call with FM-A they had her the facility was not able to support the needs of the R4 however, no bed hold was offered at the time.	F 625	by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F625, Notice of Bed Hold Policy Before/Upon Transfer. Woodlyn Heights Senior Living corrected the deficiency by reviewing R4 and all like resident charts to ensure appropriate bed hold. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were re-educated on 11/12/2021 or prior to their next scheduled shift on the bed hold policy by Scott Sommers, Interim DNS. The DNS and/or designee will audit all transfers or discharges for appropriate bed hold two times per week for 4 weeks, weekly for 4 weeks, and then randomly to ensure substantial compliance. 3. As part of Woodlyn Heights Senior Living□s ongoing commitment to quality assurance, the DNS and/or designee will	

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F 625	Continued From page 16 The facility undated Notice of Bed Hold and Readmission policy indicated "We are required to notify the resident, family or legal representative of our bed hold and readmission policy for hospitalizations and therapeutic leaves. This applies to every resident regardless of their pay source..."	F 625	report identified concerns through the community□s QA Process.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement interventions as directed by the care plan for 1 of 1 resident (R5) who rolled out of bed and to the floor and sustained an abrasion and pain reviewed for falls. Findings include: R5's annual Minimum Data Set (MDS) dated 10/19/21, indicated R5's diagnosis included quadriplegia, Multiple Sclerosis (MS), and anxiety. The MDS indicated R5 was cognitively intact and required two staff physical assistance for bed mobility, transfers, and toilet use; R5 had a functional limitation in range motion on both upper and lower extremities; R5 did not reject	F 689	F 689 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond	11/15/21

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F 689	Continued From page 17 cares and R5 had a fall with injury since the previous assessment. R5's mobility care plan dated dated 4/25/21, identified resident had limited physical mobility related to MS and was at risk for falls. The care plan directed staff for bed mobility resident required two staff assistance to reposition and turn in bed and was totally dependent on staff for repositioning and turning. R5's activities of daily living (ADL)dated 8/9/21, identified R5 had an self care performance deficit related to MS, quadriplegia, neurogenic bladder, bed and wheelchair dependence. The care plan indicated for bed mobility R5 was totally dependent on staff for repositioning and turning and requires 2 staff assistance. R5's falls Care Area Assessment (CAA) dated 10/19/21, indicated R5 was at risk for falls and was dependent on staff for all assistance with ADL's related to MS and being quadriplegic. R5's nursing assistant task sheet dated 10/19/21, indicated R5 required assistance of two staff for bed mobility which included turning and repositioning. R5 Fall Incident Report dated 10/7/21, indicated "NAR told writer resident rolled off the bed while she was attempting to change her bed sheets. Writer found resident lying on the floor next to the bed face up. Resident denied hitting head and stated a small pain in the right shoulder from a previous fall." The incident report indicated R5 had sustained an abrasion to the right front knee and the immediate action taken included checking the vital signs which were stable and R5	F 689	chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 689, Free of Accident Hazards/Supervision/Devices, Woodlyn Heights Senior Living corrected the deficiency by reviewing R5 and all like resident care plans to ensure accurate interventions. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were re-educated on 11/12/2021 or prior to their next shift on following the plan of care by Scott Sommers, Interim DNS. The DNS and/or designee will audit three resident care plans three times a week for 4 weeks, then one time a week for 4 weeks and then randomly to ensure substantial compliance. 3. As part of Woodlyn Heights Senior Living□s ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community□s QA Process.	

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F 689	Continued From page 18	F 689		

was assisted with a mechanical lift back to the bed.

A general progress note dated 10/12/21, at 2:31 p.m. indicated "Therapy reported to nursing staff that resident's pain level and swelling in right arm has worsened. They did not move that arm in therapy session due to this observation. Information reported to nurse practitioner [NP] on 10/11/21. NP had seen resident, replied on 10/12/21 that we could proceed with shoulder and arm X-ray. After discussion with rehab order was processed."

During interview on 10/20/21, at 8:37 a.m. R5 stated at the time of the incident nursing assistant (NA)-A was standing on the right side of the bed. "I rolled out of bed to the window side so fast. She was alone in the room at the time this happened." R5 further stated following the incident she had scrapped her knee and her arm and shoulder hurt and hip was bruised and she was still sore on the knee and arm since the incident and was using pain medication for pain management.

During interview on 10/21/21, at 8:53 a.m. registered nurse (RN)-B stated prior to the incident therapy had been working with R5 but after the incident when R5 rolled out of bed therapy staff had noticed more swelling and pain in the shoulder and that was why she had updated the nurse practitioner and had gotten an order to do a x-ray which was negative for fractures. RN-B further stated according to R5 the pain was well controlled.

During interview on 10/19/21, at 1:24 p.m. the director of nursing (DON) stated when the

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F 689	Continued From page 19 incident occurred the nurse stated NA-A was trying to reposition resident and in the process of trying to position the sheets, R5 had rolled out of bed. The DON stated at the time of the incident there was only one staff in the room and that was NA-A who was from the agency "pool aide." The DON stated NA-A had approached him that shift upset that the other aides working at the unit were not assisting her. The DON stated when he had followed up with the aides he was informed that when they had offered assistance NA-A had said "No." The DON stated when R5 rolled out of bed the management team had questioned how it had happened because R5 had no prior incidents as R5 was a quadriplegic and required total staff assistance. The DON reviewed R5's care plan and MDS and acknowledged R5 required total physical assistance of two staff with bed mobility which included turning and repositioning. The DON stated he expected staff to follow the plan of care when providing cares and this included the agency staff. The facility Fall Risk and Prevention Guidelines policy revised February 2019, indicated the facility was to ensure adequate interventions were in place to decrease, limit and prevent resident falls and was to ensure resident safety while maintaining their dignity and highest practical level of abilities.	F 689		