DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 19, 2022

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

RE: CCN: 245320
Cycle Start Date: April 19, 2022

Dear Administrator:

On May 12, 2022, the Minnesota Department(s) 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.

Sincerely,

Kamala Fiske-Downing

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

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April 29, 2022

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

RE: CCN: 245320
Cycle Start Date: April 19, 2022

Dear Administrator:

On April 19, 2022, 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"and/or an E tag), i.e., the plan of correction should be directed to:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 19, 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 October 19, 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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April 29, 2022

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

Re: Event ID: TR4011

Dear Administrator:

The above facility survey was completed on April 19, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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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 04/19/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/19/22, 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 was found to be substantiated: H5320088C (MN82418), with a deficiency cited at F655. The following complaint was found to be substantiated: H5320090C (MN81451), however no deficiencies were cited. The following complaint was found to be unsubstantiated: H5320089C (MN81459). 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 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident	F 655		5/9/22

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

Electronically Signed | 05/06/2022

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 655	Continued From page 1 that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 655		

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F 655	Continued From page 2 Based on interview and record review, the facility failed to develop a person-centered, baseline care plan that included resident goals, anti-coagulant medication use and precautions, and all care needs to properly care for 1 of 3 residents (R1) reviewed for baseline care plan. Findings include: R1's hospital Discharge Summary dated 3/30/22, indicated R1 had a syncopal episode (temporary loss of consciousness) due to orthostatic changes (changes with sitting or standing) in his blood pressure upon standing and fell, causing a bruise to R1's left shoulder, a skin tear to his left hand, and left elbow pain and should be placed on fall precautions upon discharge to the facility. R1 also had a history of poor sleep patterns, staying up most of the night and sleeping during the day. Interventions included facility staff keeping R1 awake during the day and encouraging sleep during the night. The discharge summary also indicated R1's goal was to return home where he lived with his wife. R1's hospital neurology consult dated 3/24/22, indicated R1 had not been able to stand since admission to the hospital due to dizziness, and had new onset of visual hallucinations to suggest Lewy body disease (a progressive dementia that affects movement, mood, memory, and behavior). R1's hospital palliative care consult dated 3/25/22, indicated R1 was restless at night and slept during the day. Recommendations were to keep R1 awake during the day and encourage sleep at night. R1's goal was to gain strength and return home.	F 655	F655 PLAN OF CORRECTION Woodlyn Heights Healthcare Center 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 F655, Baseline Care Plans, Woodlyn Heights Healthcare Center corrected the deficiency by auditing residents admitted in the last 30 days to ensure they had a baseline care plan completed 1:1 education was provided to the MDS and ADON on 5/5/2022 by April Prinzing, RN. R1 was discharged on 4/11/2022. 2. To correct the deficiency and to ensure the problem does not recur All nurses were educated on the baseline care plan completion on 5/5/2022 by ADON. The DON and/or designee will audit new admissions for baseline care plan completion 3x/weekly x 4 weeks, then	

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F 655	Continued From page 3 R1's hospitalist progress note dated 3/29/22, indicated R1 had chronic atrial fibrillation (a-fib: an irregular heartbeat that causes blood clots) with a history bilateral PEs (pulmonary embolisms: blood clots in both lungs) and DVT (deep vein thrombosis: blood clots in the legs). Interventions included the use of anti-embolism stockings (TED stockings) and an anti-coagulant (blood thinner) medication. R1's admission progress note dated 3/30/22, indicated R1 had a recent change in his sleep pattern and sometimes napped during the day. The note also indicated R1 had bruises and abrasions and referred to R1's care plan for treatments and interventions. R1 required moderate assistance for dressing and maximal assistance for bed mobility and transfers. The note also indicated R1 was not ambulatory, required a wheelchair, and was dependent for toileting. R1's admission Minimum Data Set (MDS) dated 4/5/22, indicated R1 admitted to the facility on 3/30/22, and had mild cognitive deficits. R1 required extensive assistance of two staff for bed mobility, transfers, and toileting and extensive assistance of one staff for personal hygiene, and dressing. R1 had diagnoses including; overactive bladder, atrial fibrillation, anxiety, and Parkinson's (a progressive disease that affects movement and stability). R1's Care Area Assessments (CAAs) dated 4/5/22, indicated R1 triggered for cognitive loss/dementia, communication related to an impaired ability to make himself understood and to understand others, activities of daily living	F 655	2x/weekly x2 weeks, then PRN to ensure continued compliance. 3. As part of Woodlyn Heights Healthcare Center's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QAPI Process.	

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F 655	Continued From page 4 (ADLs) related to R1's requiring extensive assistance for ADLs, urinary incontinence, and falls related to R1 having a history of falls and balance problems. R1's Physician Orders dated 3/30/22, indicated R1 took Eliquis (a blood thinner) 2.5 milligrams (mg). R1's Functional Review Safe Patient Handling dated 3/31/22, indicated R1's level of assistance was dependent. R1 used equipment for transfers and repositioning and did not use ambulation equipment (four-wheeled walker). R1's Fall Risk Summary dated 3/31/22, indicated R1 was a high risk for falls and did not use ambulatory aids (four-wheeled walker). R1's baseline care plan dated 4/2/22, indicated R1 had an ADL self-care deficit but lacked a reason, goal or interventions including R1's staffing requirements for dressing or toileting, R1's preference for wake and sleep times or hospital recommendations regarding sleep patterns. The care plan indicated R1 was at risk for falls due to limited physical mobility; however, lacked information regarding R1's recent history of falls and their possible causes as indicated in the hospital discharge summary. The care plan further indicated R1 was non-ambulatory; however, interventions indicated R1 used a four-wheeled walker for transfers. The care plan further indicated R1 had an alteration in hematological status (blood related issues) however, lacked a reason, goals, or interventions regarding R1's use of anti-coagulant medications, having an implanted pacemaker, or the hospital recommendation for TED stockings. The care	F 655		

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F 655	Continued From page 5	F 655		

plan also lacked any indication of, treatments, or interventions for R1's bruises and abrasions observed upon admission.

During an interview on 4/19/22, at 1:26 p.m. family member (FM)-A stated while visiting R1, a nursing assistant (NA) entered the room and attempted to make R1 use a walker because that was what was on the NA's care sheet, although R1 was not ambulatory and required a mechanical lift for transfers. FM-A stated she called the director of nursing (DON) who agreed the care sheet was incorrect. The DON and unavailable for an interview.

During an interview on 4/19/22, at 2:28 p.m. registered nurse (RN)-A stated when a resident admitted from the hospital, a nurse would review the hospital discharge papers and complete an admission assessment to determine how the staff should care for the resident. The information would be used to create a baseline care plan and entered on the NA care sheets.

During an interview on 4/19/22, at 2:50 p.m. NA-A stated when a resident was admitted from the hospital, a nurse would assess the resident then tell the NA's how to transfer and care for the resident. NA-A stated the information would also be put on a care sheet and entered in the computer.

During an interview on 4/19/22, at 2:56 p.m. assistant director of nursing (ADON) stated a nurse would review a new resident's hospital discharge paperwork and complete an admission assessment to create a baseline care plan within 24 hours of a resident's arrival to the facility. The ADON stated the information would also be

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F 655	Continued From page 6 added to a care sheet so the NAs would know how to care for the resident. Facility Fall Risk and Prevention Guidelines dated February 2019, indicated staff were to review hospital records and/or interview the resident and/or family to determine the resident's fall history and risk factors to include their medical conditions, medications, cognitive function, physical functioning, and behaviors). The guideline also indicated a resident's care plan would identify a resident's history of falls, risk areas consistent with a resident's specific conditions, needs, behaviors, and preferences. All interventions were to be listed in the care plan and the NA care sheets. A facility policy regarding baseline care plans was requested from the facility but not received.	F 655		