



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 19, 2023

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

RE: CCN: 245320
Cycle Start Date: April 19, 2023

Dear Administrator:

On May 15, 2023, 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.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 19, 2023

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

Re: Reinspection Results
Event ID: FGNF12

Dear Administrator:

On May 15, 2023 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 19, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



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Electronically delivered
April 26, 2023

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

RE: CCN: 245320
Cycle Start Date: March 15, 2023

Dear Administrator:

On April 19, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 19, 2023 (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, 2023 (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/lrc_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.

Woodlyn Heights Healthcare Center

April 26, 2023

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing

Minnesota Department of Health

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: 245320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/19/2023
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 4/17/23, 4/18/23, and 4/19/23 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed during the survey: H53201360C (MN92654), H53201443C (MN89244 and MN89404), and H53201442C (MN89269) with a deficiency issued at F554. 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the resident and determine safety for self-administration of medications (SAM) for 1 of 1 resident (R2) who	F 554	F 554 PLAN OF CORRECTION Woodlyn Heights denies it violated any federal or state regulations. Accordingly,	5/6/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

05/03/2023

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 554	Continued From page 1 was observed to have her medications in a cup. Findings include: During an observation and interview on 4/18/23, at 3:53 p.m. R2 was seated in her recliner, next to her recliner on the bedside table was a clear plastic one ounce med cup with several pills in it. R2 reported the medications were given to her by staff this morning; R2 identified the pills in the cup were vitamins (vitamin C, D and B) and minerals (magnesium, calcium, probiotic, and turmeric). R2 explained she did not take all the medications yet, because they fill her up and would take them throughout the day. R2 stated some nurses would say they needed to watch her take them, however she would refuse. She has told the nurses many times she could not take them all together, but still had to argue with them. R2's quarterly Minimum Data Set (MDS) R2 had intact cognition, required supervision to independence with her activities of daily living (ADL)'s, and indicated diagnoses of age-related osteoarthritis, thiamin deficiency, and hypomagnesemia. R2' medication administration record (MAR), dated April, 2023, indicated that in the morning of 4/18/23, R2 was administered the following medications: two tablets of ascorbic acid 500 milligrams (mg) (vitamin C supplement), two tablets of Glucosamine 750 mg (helps to lubricate joints) , Lactobacillus Rhamnoses 1 capsule (probiotic), magnesium 300 mg tablet, multivitamin tablet, thiamine 100 mg tablet (for deficiency), Turmeric 500 mg tablet (supplement), Vitamin D3, 25 micrograms (mcg) tablet, and calcium carbonate 600 mg tablet (for	F 554	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 554, Resident Self-Admin Meds-Clinically Appropriate, the right to self-administer medications (SAMs). The Director of Nursing corrected the deficiency by completing the self-administer medication assessment for R2 on 04/27/2023. All residents have been reviewed, and for any residents that wish to self-administer medications, a SAMs assessment was completed by 5/06/2023. 2. To correct the deficiency and to ensure the problem does not recur, Nurses and TMAs were educated on 05/05/2023 or prior to their next scheduled shift on the self-administration of medication policy and process by the DON. 3. The DON and/or designee will audit the self-administration of medications by observing medication pass on varying shifts 5x/week for 4 weeks, 2x/week for 8		

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F 554	Continued From page 2 osteoporosis) for a total of 11 different supplements. During an interview on 4/18/23, at 4:57 p.m. registered nurse (RN)-A reviewed R2's record and stated R2 did not have a self-administration medication (SAM) assessment. Since R2 did not have a completed SAM the medications should not have been left with R2 because it was unknown if it was safe for R2 to self-administer. During an interview on 4/18/23, at 4:59 p.m. interim director of nursing (IDON), indicated that R2 did not have a SAM assessment completed and a physician order was not obtained (per policy). IDON stated, the pills from the morning medication pass should not have been left with R2. IDON was not sure if any of the residents are getting the SAM assessments completed and stated they should be. Facility policy, "Medication Self Administration Safety Screen and/or Self Administration," revised 2018, indicated a purpose to ensure resident safety for those residents that prefer to self-administration of medications. Guideline: The Medication Self Administration Safety Screen and/or the Self Administration of Nebulizer's Evaluation is only completed if the resident requests to do their own medications or some of their own medications such as inhalers, eye drops or actual pills. The Medication Self Administration Safety Screen will be completed prior to the resident initiating self-administration of medications and with any medication changes, changes in function/condition that might affect the resident's ability to safely self-administer medications. Ongoing evaluation should occur at a minimum of quarterly. The IDT will review the	F 554	weeks, and then randomly to ensure continued compliance. 4. As part of Woodlyn Heights ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.		

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F 554	Continued From page 3 summary on the Medication Self Administration Safety Screen to determine appropriateness of self-administration of medications. The determination will include whether the resident can self-administer medications unsupervised, with supervision or is not safe to administer medications. A physician order will be obtained indicating which medications the resident may self-administer and with or without supervision.	F 554			



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Electronically delivered
April 26, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: FGNF11

Dear Administrator:

The above facility was surveyed on April 17, 2023 through April 19, 2023 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.

Woodlyn Heights Healthcare Center

April 26, 2023

Page 2

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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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.

Sincerely,



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00829	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 4/17/23, 4/18/23 and 4/19/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you	2 000		

Minnesota Department of Health		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/03/23

Minnesota Department of Health

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H53201360C (MN92654), H53201443C (MN89244 and MN89404), and H53201442C (MN89269) with a licensing order issued at 1565 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	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00829	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/19/2023
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2 000	Continued From page 2 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		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the resident and determine safety for self-administration of medications (SAM) for 1 of 1 resident (R2) who was observed to have her medications in a cup. Findings include: During an observation and interview on 4/18/23, at 3:53 p.m. R2 was seated in her recliner, next to her recliner on the bedside table was a clear plastic one ounce med cup with several pills in it. R2 reported the medications were given to her by staff this morning; R2 identified the pills in the cup were vitamins (vitamin C, D and B) and minerals (magnesium, calcium, probiotic, and turmeric). R2 explained she did not take all the medications yet, because they fill her up and would take them	21565	F 554 PLAN OF CORRECTION Woodlyn Heights 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	5/6/23

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21565	Continued From page 3 throughout the day. R2 stated some nurses would say they needed to watch her take them, however she would refuse. She has told the nurses many times she could not take them all together, but still had to argue with them. R2's quarterly Minimum Data Set (MDS) R2 had intact cognition, required supervision to independence with her activities of daily living (ADL)'s, and indicated diagnoses of age-related osteoarthritis, thiamin deficiency, and hypomagnesemia. R2' medication administration record (MAR), dated April, 2023, indicated that in the morning of 4/18/23, R2 was administered the following medications: two tablets of ascorbic acid 500 milligrams (mg) (vitamin C supplement), two tablets of Glucosamine 750 mg (helps to lubricate joints) , Lactobacillus Rhamnoses 1 capsule (probiotic), magnesium 300 mg tablet, multivitamin tablet, thiamine 100 mg tablet (for deficiency), Turmeric 500 mg tablet (supplement), Vitamin D3, 25 micrograms (mcg) tablet, and calcium carbonate 600 mg tablet (for osteoporosis) for a total of 11 different supplements. During an interview on 4/18/23, at 4:57 p.m. registered nurse (RN)-A reviewed R2's record and stated R2 did not have a self-administration medication (SAM) assessment. Since R2 did not have a completed SAM the medications should not have been left with R2 because it was unknown if it was safe for R2 to self-administer. During an interview on 4/18/23, at 4:59 p.m. interim director of nursing (IDON), indicated that R2 did not have a SAM assessment completed and a physician order was not obtained (per	21565	maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 554, Resident Self-Admin Meds-Clinically Appropriate, the right to self-administer medications (SAMs). The Director of Nursing corrected the deficiency by completing the self-administer medication assessment for R2 on 04/27/2023. All residents have been reviewed, and for any residents that wish to self-administer medications, a SAMs assessment was completed by 5/06/2023. 2. To correct the deficiency and to ensure the problem does not recur, Nurses and TMAs were educated on 05/05/2023 or prior to their next scheduled shift on the self-administration of medication policy and process by the DON. 3. The DON and/or designee will audit the self-administration of medications by observing medication pass on varying shifts 5x/week for 4 weeks, 2x/week for 8 weeks, and then randomly to ensure continued compliance. 4. As part of Woodlyn Heights ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00829	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077			
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21565	Continued From page 4 policy). IDON stated, the pills from the morning medication pass should not have been left with R2. IDON was not sure if any of the residents are getting the SAM assessments completed and stated they should be. Facility policy, "Medication Self Administration Safety Screen and/or Self Administration," revised 2018, indicated a purpose to ensure resident safety for those residents that prefer to self-administration of medications. Guideline: The Medication Self Administration Safety Screen and/or the Self Administration of Nebulizer's Evaluation is only completed if the resident requests to do their own medications or some of their own medications such as inhalers, eye drops or actual pills. The Medication Self Administration Safety Screen will be completed prior to the resident initiating self-administration of medications and with any medication changes, changes in function/condition that might affect the resident's ability to safely self-administer medications. Ongoing evaluation should occur at a minimum of quarterly. The IDT will review the summary on the Medication Self Administration Safety Screen to determine appropriateness of self-administration of medications. The determination will include whether the resident can self-administer medications unsupervised, with supervision or is not safe to administer medications. A physician order will be obtained indicating which medications the resident may self-administer and with or without supervision. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to	21565			

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21565	Continued From page 5 evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565			