Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 22, 2022

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

RE: CCN: 245320
Cycle Start Date: June 9, 2022

Dear Administrator:

On June 27, 2022, we notified you a remedy was imposed. On August 18, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 1, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 12, 2022 be discontinued as of August 1, 2022. (42 CFR 488.417 (b))

In our letter of June 27, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 12, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

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 06/09/2022

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) COMPLETE DATE
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 , 6/9/22 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 when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H53202075C (MN84013), with a licensing order issued at 0835. 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 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, monitor, and follow physician orders for a surgical wound for 1 of 1 (R1) resident reviewed who had a surgical wound. Findings include: R1's admission Minimum Data Set (MDS) dated 5/26/22, indicated R1 was admitted to the facility on 5/20/22. R1 was cognitively intact with diagnosis including intervertebral disc degeneration of lumbrosacral region. R1 required assistance with turning and repositioning. R1's MDS also indicated R1 had a surgical wound with no rejection of care. R1's hospital discharge summary indicated R1	2 835	(0835) MN Rule 468.0520 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	7/1/22

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2 835	Continued From page 3 was discharged from the hospital after spinal surgery on 5/20/22. The summary identified physician orders for surgical incision care to change the dressing to R1's back as needed if soaked or drainage noted, do not soak (incision) in bath or tub, do not scrub incision site, may wash with soap/water and pat dry, leave steri-strips in place to fall off on their own, and it's okay if incision gets wet. R1's care plan reviewed on 6/9/22, indicated R1 had an actual skin impairment with interventions to monitor wound daily and to report signs and symptoms to a medical practitioner. R1's physician order summary report dated 5/23/22, did not include the incisional treatment orders identified in the hospital discharge summary. R1's encounter note dated 5/23/22, indicated the nurse practitioner (NP)-A assessed the surgical wound and noted increased redness, warmth, and purulent drainage. NP-A placed R1 on the antibiotic Doxycycline Hyclate twice a day for 14 days with a diagnosis of post-op infection. R1's record lacked evidence of comprehensive assessments and surgical wound monitoring for changes and signs and symptoms of infection. In addition, R1's Treatment Administration Record (TAR) dated 5/1/22 through 5/31/22, indicated the ordered treatment to the incision had not been completed in accordance with R1's hospital discharge orders. During an interview on 6/9/22, at 12:24 p.m. licensed practical nurse (LPN)-A stated physician orders for surgical wound care and site monitoring for signs and symptoms of infection	2 835	maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with (0835) MN Rule 468.0520, Quality of Care, Woodlyn Heights Senior Living corrected the deficiency by providing 1:1 education to staff who entered orders for resident R1 on 6/23/2022.A head-to-toe skin assessment was completed on all like residents, physicians were notified, and treatment orders received by 6/27/2022by Interim Director of Nursing. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 6/23/22 or prior to next shift, on: entering admission orders into PCC completely, treatments must be done as ordered by physician, assessment of wounds when completing wound treatments ensuring no s/sx of infection and ensuring documentation in nurses notes is completed with changes of wound condition. Audits that identified skin issues are being assessed and documented on weekly by the DON/ADON. The DON and/or designee will audit all new admissions to ensure orders were put in PCC correctly and audit 3 dressing changes 3x week to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community□s QA Process.	

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2 835	Continued From page 4 would be noted on the TAR. LPN-A stated the surgical wound should have been monitored every shift or according to physician orders. LPN-A further indicated she had not monitored R1's surgical wound or completed a dressing change. During an interview on 6/9/22, at 12:40 p.m. LPN-B stated when receiving physician orders for wound monitoring and wound care the documentation would be noted on the TAR. During an interview on 6/9/22, at 12:44 p.m. NP-B stated the expectation would be for the facility staff to monitor the surgical wound daily and if any changes follow up with the surgeon. Further, the expectation for wound care would be for the facility staff to follow the physician orders. During an interview on 6/9/22, at 1:01 p.m. the assistant director of nursing (ADON) stated wound orders from the discharging hospital should be documented in the physician orders and the nurses should be monitoring the surgical incision at least every shift for signs and symptoms of infection and document the assessment in the progress notes. The weekly skin assessment and documentation process policy dated 6/15/21, indicated non-ulcers will be assessed and documented weekly by the facility wound nurse and treatment orders will be implemented per protocol. SUGGESTED METHOD OF CORRECTION: The DON/designee could review/revise surgical wound care protocols and polices. DON/designee could provide re-education to staff on wound care in addition to order transcription from the hospital discharge summary. The DON/designee could	2 835		

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2 835	Continued From page 5 then develop and implement an auditing system as part of quality control activities to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 22, 2022

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

Re: Reinspection Results
Event ID: W5ED12

Dear Administrator:

On July 16, 2022 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 June 9, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Electronically delivered
June 23, 2022

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

RE: CCN: 245320
Cycle Start Date: June 9, 2022

Dear Administrator:

On June 9, 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:

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 September 9, 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 December 9, 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

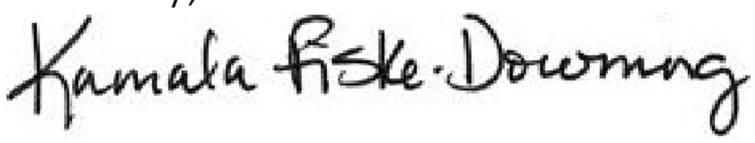
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 23, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: W5ED11

Dear Administrator:

The above facility was surveyed on June 9, 2022 through June 9, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

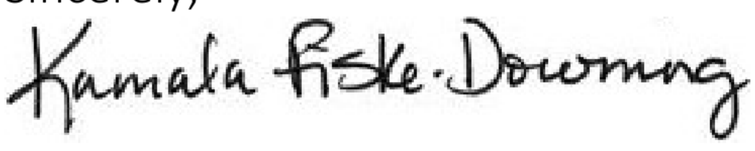
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

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

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F 000	INITIAL COMMENTS On 6/9/22, 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 complaints were found to be SUBSTANTIATED: H53202075C (MN84013), with deficiencies cited at F684 and F690. 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		7/1/22

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

Electronically Signed | 07/01/2022

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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(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 684	Continued From page 1 Based on interview and document review, the facility failed to comprehensively assess, monitor, and follow physician orders for a surgical wound for 1 of 1 (R1) resident reviewed who had a surgical wound. Findings include: R1's admission Minimum Data Set (MDS) dated 5/26/22, indicated R1 was admitted to the facility on 5/20/22. R1 was cognitively intact with diagnosis including intervertebral disc degeneration of lumbrosacral region. R1 required assistance with turning and repositioning. R1's MDS also indicated R1 had a surgical wound with no rejection of care. R1's hospital discharge summary indicated R1 was discharged from the hospital after spinal surgery on 5/20/22. The summary identified physician orders for surgical incision care to change the dressing to R1's back as needed if soaked or drainage noted, do not soak (incision) in bath or tub, do not scrub incision site, may wash with soap/water and pat dry, leave steri-strips in place to fall off on their own, and it's okay if incision gets wet. R1's care plan reviewed on 6/9/22, indicated R1 had an actual skin impairment with interventions to monitor wound daily and to report signs and symptoms to a medical practitioner. R1's physician order summary report dated 5/23/22, did not include the incisional treatment orders identified in the hospital discharge summary. R1's encounter note dated 5/23/22, indicated the	F 684	F (684) 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 (684), Quality of Care, Woodlyn Heights Senior Living corrected the deficiency by providing 1:1 education to staff who entered orders for resident R1 on 6/23/2022. R1 is no longer a resident in our facility. A head-to-toe skin assessment was completed on all like residents, physicians were notified, and treatment orders received by 6/27/2022 by Interim Director of Nursing. 2. All residents received a body audit to identify any areas of concern. Treatment orders were obtained for all wounds identified. 3. To correct the deficiency and to ensure the problem does not recur all staff were	

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F 684	Continued From page 2 nurse practitioner (NP)-A assessed the surgical wound and noted increased redness, warmth, and purulent drainage. NP-A placed R1 on the antibiotic Doxycycline Hyclate twice a day for 14 days with a diagnosis of post-op infection. R1's record lacked evidence of comprehensive assessments and surgical wound monitoring for changes and signs and symptoms of infection. In addition, R1's Treatment Administration Record (TAR) dated 5/1/22 through 5/31/22, indicated the ordered treatment to the incision had not been completed in accordance with R1's hospital discharge orders. During an interview on 6/9/22, at 12:24 p.m. licensed practical nurse (LPN)-A stated physician orders for surgical wound care and site monitoring for signs and symptoms of infection would be noted on the TAR. LPN-A stated the surgical wound should have been monitored every shift or according to physician orders. LPN-A further indicated she had not monitored R1's surgical wound or completed a dressing change. During an interview on 6/9/22, at 12:40 p.m. LPN-B stated when receiving physician orders for wound monitoring and wound care the documentation would be noted on the TAR. During an interview on 6/9/22, at 12:44 p.m. NP-B stated the expectation would be for the facility staff to monitor the surgical wound daily and if any changes follow up with the surgeon. Further, the expectation for wound care would be for the facility staff to follow the physician orders. During an interview on 6/9/22, at 1:01 p.m. the	F 684	educated on 6/23/22 or prior to next shift, on entering admission orders into PCC correctly, treatments must be done as ordered by physician, assessment of wounds when completing wound treatments, ensuring no s/sx of infection and ensuring documentation in nurses notes is completed with changes of wound condition. All new admissions will receive a comprehensive skin assessment on admission along with appropriate treatments. 4. Audits that identified skin issues are being assessed and documented on weekly by the DON/ADON. The DON and/or designee will audit all new admissions to ensure orders were put in PCC correctly and audit 3 dressing changes 3x week to ensure continued compliance. As part of Woodlyn Heights Senior Living 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 684	Continued From page 3 assistant director of nursing (ADON) stated wound orders from the discharging hospital should be documented in the physician orders and the nurses should be monitoring the surgical incision at least every shift for signs and symptoms of infection and document the assessment in the progress notes. The weekly skin assessment and documentation process policy dated 6/15/21, indicated non-ulcers will be assessed and documented weekly by the facility wound nurse and treatment orders will be implemented per protocol.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		7/1/22

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F 690	Continued From page 4 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not appropriately manage indwelling urinary catheters to prevent urinary tract infection. The facility failed to perform catheter care in accordance with the care plan and failed to properly insert a Foley catheter (a closed sterile system with a catheter and retention balloon that is inserted either through the urethra or suprapubically to allow for bladder drainage) for 1 of 3 residents (R1), failed to monitor and assess for signs/symptoms of complications and infection for 3 of 3 residents (R1, R2, R3), failed to appropriately clean/disinfect catheter tubing and accessories for 2 of 3 residents (R2, R3) reviewed for catheters. Findings include: R1 admission Minimum Data Set (MDS) dated 5/26/22, indicated R1 was admitted to the facility on 5/20/22, was cognitively intact, and had diagnoses that included intervertebral disc degeneration of lumbrosacral region and urinary	F 690	F (690) 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 (690), Bowel/Bladder Incontinence, Catheter, UTI, Woodlyn Heights Senior	

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F 690	Continued From page 5 retention. Further, MDS indicated R1 had an indwelling urinary catheter. R1's care plan reviewed on 6/9/22, indicated R1 had an indwelling Foley catheter with interventions to cover catheter bag at all times, catheter cares BID (twice a day), and check tubing for kinks during rounds and PRN (as needed). The care plan did not address R1's risk for UTI's and/or monitoring for signs and symptoms of infection. R1's discharge orders from the hospital dated 5/20/22, included a physician order to remove Foley catheter for voiding trial on 5/22/22, and if unable to void after six hours, bladder scan and straight cath if over 600cc of urine and inform provider. R1's progress note dated 5/21/22, at 10:02 p.m. indicated R1 pulled out the Foley catheter earlier in the a.m. and the registered nurse (RN)-A attempted to reinsert the catheter two times and was successful at 9:00 p.m. R1's progress note did not include an assessment or address if inappropriate removal of the foley catheter caused trauma to R1's urethra or bladder, and did not address how R1 tolerated the catheter reinsertion procedure. R1's record lacked evidence the physician was notified of R1 pulling the catheter out and R1's order summary report dated 5/23/22, did not include a physician order to re-insert the catheter on 5/21/22. R1's progress note dated 5/22/22, at 7:34 a.m. indicated RN-A removed catheter at 7:00 a.m.	F 690	Living corrected the deficiency by providing immediate education to N-A on catheter care process, documentation, and monitoring for s/sx of infection on 6/23/2022 by ADON. Immediate education was provided to NA-B and NA-C on catheter care, s/s of infection and storage of catheter bags and graduates on 6/23/2022. RN-1 received immediate education on catheter insertion by ADON on 6/23/2022. LPN-A received immediate education on 6/23/2022 on monitoring for s/s of UTI. 2. All like residents had a comprehensive assessment completed and care plans were updated with interventions and/or orders which includes monitoring for s/s of infection. 3. To correct the deficiency and to ensure the problem does not recur all staff were educated on 6/23/22 or prior to next shift on: Education to nurses on documentation of procedural care (catheter insertion); assessment, intervention, and documentation for signs/symptoms of urinary tract infection and timely physician notification. Education to all nurses and CNA's on catheter care process, proper storage of catheters in a dignity bag, and cleanliness/storage/changing of graduate containers for catheters. All like residents had a comprehensive assessment completed and care plans were updated with interventions and/or orders which includes monitoring for s/s of infection. 4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the	

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F 690	Continued From page 6 R1's record lacked evidence of monitoring for signs and symptoms of UTI. R1's emergency department physician note dated 5/23/22, indicated R1 complained of burning during urination and stated RN-A had inserted the catheter in the vagina and then into the urinary bladder without using sterile technique. Further, the physician indicated the diagnosis of cystitis. During an interview on 6/9/22, at 1:38 p.m. registered nurse (RN)-E indicated she was the nurse that cared for R1 when she pulled the catheter out. RN-E stated she had not attempted to reinsert the catheter. RN-E indicated she had not accurately documented to reflect R1's refusals to insert the catheter and the documentation was incomplete. During an interview on 6/9/22, at 3:44 p.m. hospital social worker (SW) indicated she was familiar with R1. SW stated R1 reported having nightmares about the catheter incident during hospital stay but did not know the details of the nightmares. SW stated R1 reported to her that she had pulled out her catheter herself because her surgeon had told her it was only supposed to be in for a few days. SW stated R1 indicated the nurse had told her she (R1) could not remove the catheter and the removal needed to be done by the nurse. SW indicated R1 reported the nurse tried to reinsert the catheter multiple times. During an interview on 6/9/22, at 4:02 p.m. R1 stated she remembered very well what happened with the catheter and had nightmares over it. R1 stated the nurse kept "poking and poking" it in using the same catheter, it seemed like it went on for 45 minutes, and the nurse never left the room	F 690	community□s QA Process. The DON and/or designee will audit catheter cares, changing and storage of graduate containers 3x weekly x 4 weeks, then 2x weekly x 2 weeks, then PRN to ensure continued compliance. The DON and/or designee will monitor hot charts to ensure physicians are notified timely for intervention if resident having s/sx of infection 3x/weekly x 4 weeks, then 2x weekly x 2 weeks, then PRN to ensure continued compliance.	

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F 690	Continued From page 7 to get a new catheter. R2's admission MDS dated 5/3/22, indicated R2 was cognitively intact with diagnosis of end stage renal disease. Further, indicated R2 had an indwelling catheter. R2's care plan dated 5/3/22, indicated R2 has a suprapubic catheter (inserted into the bladder through the abdomen) with interventions to cover catheter bag at all times, catheter cares BID, and check tubing for kinks during rounds and PRN. The care plan did not address R2's risk for UTI's and/or monitoring for signs and symptoms of infection. R2's order summary report dated 5/23/22, included the following orders for the suprapubic catheter: -Change suprapubic catheter monthly and as needed if plugged or bypassing, change at urology every day shift every 30 days until 5/27/22. -Flush suprapubic catheter with 10 milliliters of normal saline as needed (start date 4/27/22) R2's TAR dated 5/1/22 through 5/31/22, indicated R2's suprapubic catheter was changed on 5/27/22. R2's progress notes did not address the suprapubic catheter being changed on 5/27/22. R2's TAR did not indicate flushes were attempted prior to changing. R2's progress note dated 5/31/22, indicated R2's suprapubic catheter was changed due to severe	F 690		

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F 690	Continued From page 8 discomfort and urine not draining. The note did not identify how R2 tolerated the procedure, and if R2's symptoms were relieved after the catheter was changed. R2's record lacked evidence of monitoring for signs and symptoms for urinary tract infection, did not include evaluations/assessments of catheter patency, and did not identify how often and/or when R2's graduate was changed and/or disinfected During observation on 6/9/22, at 12:06 p.m. R2's urinary graduate was on the back of the toilet with no date and not covered. During an interview on 6/9/22, at 12:32 p.m. R2 stated when the nurse changed her catheter last, she kept "poking it in and out and it hurt horribly." R2 stated NAs did not use alcohol wipes when emptying drainage bag; they used the disinfectant wipes with the purple top to clean it. R2 indicated she kept her own supply of alcohol wipes and instructed the NAs to use them. Upon reviewing the label of the sani-cloths on 6/9/22, the label indicated all blood and body fluids must be thoroughly cleaned from surface and objects prior to disinfection. R3's quarterly MDS dated 4/11/22, indicated R3 cognitively intact with diagnosis of end stage renal disease. Further, indicated R3 had an indwelling catheter. R3's care plan dated 9/27/21, indicated R3 has a suprapubic catheter with interventions to cover catheter bag at all times, catheter cares BID, and	F 690		

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F 690	Continued From page 9 to check tubing for kinks during rounds and PRN. The care plan did not identify R3's risk for UTI's and monitoring for signs and symptoms of infection. R3's record lacked evidence R3 was monitored for signs and symptoms of UTI and did not identify when R3's urinary graduate was disinfected or changed. During an observation on 6/9/22, at 12:02 p.m. R3's urinary drainage bag was laying on the floor next to the bed. The urinary graduate was on the back of the toilet with no date, not covered, and with a small amount of dark yellow urine in the bottom. During an interview on 6/9/22, at 11:45 a.m. nursing assistant (NA)-A stated it was our (NAs) job to monitor resident's urine integrity and if there were changes then they would report to a nurse, the nurse would look at the urine later. Further, NA-A stated when emptying the urinary bag alcohol wipes were not used as they were unavailable, so she used the sani-cloths to clean it. During an interview on 6/9/22, at 11:56 a.m. NA-B stated when emptying the urinary bag alcohol wipes were not available, so she used the sani-cloths to clean it. NA-B indicated when she would drain the collection bag, the urinary graduate was placed on the floor without a barrier. During an interview on 6/9/22, at 11:59 a.m. NA-C stated when emptying the urinary bag, she used the sani-cloths to clean it and placed the urinary graduate on the floor without using a barrier.	F 690		

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F 690	Continued From page 10 During an interview on 6/9/22, at 12:20 p.m. licensed practical nurse (LPN)-A stated the NAs were responsible for monitoring the urine and informing the nurse if there were any changes and then she would document the changes in the nurses notes. Further, stated there's no official system to monitor those residents with catheters for signs and symptoms of infection. During an interview on 6/9/22, at 12:24 p.m. LPN-B stated the NAs should inform me of any changes in the urine and then would document the changes in the nurse's notes. During an interview on 6/9/22, at 12:44 p.m. nurse practitioner (NP)-A stated the expectation if a catheter was pulled out was for the nurse to call and inform the doctor and get a new order prior to replacing the catheter. During an interview on 6/9/22, at 1:01 p.m. the assistant director of nursing (ADON) stated the expectation of the procedure on emptying urinary drainage bags was for the NAs to clean the tubing with alcohol swabs and do not place the urinary graduate on the floor. Further, the NAs were to clean the urinary graduate and then place it in a bag. The urinary graduate should be changed out weekly and dated. The expectation for monitoring for signs and symptoms of urinary infection was the NAs were to notify the nurses if there were any changes and then the nurses would be expected to complete an assessment and inform the provider. The assessment and the phone call to the provider should be documented in the nurses notes. ADON verified the sani-cloths were not to be used on body fluids.	F 690		

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F 690	Continued From page 11 A policy for foley/suprapubic catheter insertion, emptying a urinary drainage bag, and monitoring for signs and symptoms of infection requested however, was not provided by the facility.	F 690		