



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 27, 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 23, 2022, we informed you that we may impose enforcement remedies.

On June 17, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 12, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 12, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 12, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 12, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Woodlyn Heights Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 12, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro A 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: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 9, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

Woodlyn Heights Healthcare Center

June 27, 2022

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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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2022
FORM APPROVED
OMB NO. 0938-0391

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 06/17/2022	
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 6/16/22-6/17/22, 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: H53202297C (MN84279), with deficiencies cited at F684. The following complaint was found to be UNSUBSTANTIATED: H53202298C (MN84333). 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.			F 684			7/7/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/07/2022

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 684	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow resident care policies to ensure proper procedures were followed for 1 of 1 residents (R1) who went on a leave of absence and did not return and the staff were not aware R1 was missing. Findings include: R1's admission Minimal Data Set (MDS) dated 6/12/22, indicated R1 admitted to the facility on 6/8/22. R1 required supervision or touching assistance for mobility. R1's diagnoses list printed 6/16/22, included traumatic subarachnoid hemorrhage (brain bleed because of injury), delirium, insomnia, and restlessness and agitation. R1's care plan indicated R1 had an ADL (activities of daily living) self-care deficit with interventions listed assist with dressing/undressing, set up for eating, and preferred wake time of 7:00 a.m. and bedtime of 10:00 p.m. R1's care plan indicated R1 had limited physical mobility and required one staff for assistance with ambulation. R1's care plan indicated R1 had difficulty sleeping and instructed staff to implement sleep log and sleep encouragement techniques. R1's medication administration record (MAR) indicated eight medications were not given on 6/12/22, with a chart code of 5-hold/see progress notes. R1's progress notes dated 6/12/22, at 19:29 p.m. through 22:42 p.m. indicated the eight	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 the scheduler on 6/20/22 by the ED/DON on ensuring that agency staff have been educated by using the Agency Staff Checklist. Resident R1 is no longer in facility. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated by 7/7/22 or prior to the start of their next shift on the Leave of Absence process. The DON and/or designee will audit weekly x4 weeks, then 2x a month x1 month, and then PRN to ensure		

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F 684	Continued From page 2 medications were not given due to, "pt [patient] not in room." R1's progress notes lacked any communication regarding R1 leaving the facility for a planned event with family nor R1's absence on the evening or night shift of 6/12/22. Review of the facility investigation file indicated R1 left the facility on 6/12/22, at 1:30 p.m. with family member (FM)-A to attend a graduation parry and would return after the event. The file further indicated R1 did not return the facility which was not discovered until the morning of 6/13/22. When interviewed on 6/16/22, at 9:31 a.m. licensed practical nurse (LPN)-A stated it was very important to know when the resident was expected to return from an outing or appointment. LPN-A further stated, she would call family if the resident had not returned by 30 minutes after their expected return time. LPN-A stated it was important to know how long the resident would be gone and if they needed to take their medications with them. When interviewed on 6/16/22, at 9:51 a.m. nursing assistant (NA)-A stated the standard process would be to receive report from either the nurse or the resident's family regarding when the resident would be expected to return to the facility. NA-A stated it was important to know if the resident would be returning shortly after a meal and would like the meal to be held for them. When interviewed on 6/16/22, at 11:30 a.m. LPN-B stated if a resident was going out with family it should be communicated staff to staff	F 684	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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F 684	Continued From page 3 verbally and that the expected return time should be known and passed along. LPN-B further stated she would not let too much time pass after the expected return time to start investigating and would start by calling family. When interviewed on 6/16/22, at 1:18 p.m. NA-B stated she worked with R1 on 6/12/22 and that R1 was ambulatory with a 4-wheel walker. NA-B stated R1 left that day with FM-A and asked to have her dinner saved that evening as she thought she would be back just after dinner. NA-B stated she reported this information to (LPN-C) and told her she need to pass it on to the next shift and enter a note in a communication book. NA-B stated she was right in the middle of assisting a different resident so she could not walk out with R1, and FM-A. NA-B stated the resident was supposed to sign out in the book at the facility entrance indicating when they left and when they expected to return. NA-B stated she worked the morning of 6/13/22, got report as usual and started answering call lights on the 100 unit. NA-B stated she finally got to R1's room about 7:45 a.m. to deliver a breakfast tray and saw that R1 was not in her room. NA-B stated she immediately inquired with registered nurse (RN)-A who must have notified administration because soon after that social worker (SW-A) and assistant director of nursing (ADON) began questioning her. When interviewed on 6/16/22, at 2:51 p.m. LPN-D stated it was the staff's responsibility to ensure the resident signed out when the left the facility and that the sign out sheets were kept at the nurse's station. LPN-D further stated if for some reason they did not sign out, the staff should get a verbal confirmation from the resident	F 684			

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F 684	Continued From page 4 regarding their expected return time and that information should be passed on to the next shift. LPN-D stated she would call the resident or the family to inquire about their expected return if they were gone for too long or over a medication pass. When interviewed on 6/16/22, at 3:00 p.m. LPN-E stated he rounds on all assigned residents at the start of the shift and confirm their presence in the facility. LPN-E stated if unable to find a resident he would first check the appointment book and then the sign out book by the door. LPN-E stated it was important to know the whereabouts of his assigned residents. When interviewed on 6/16/22, at 2:32 p.m. LPN-C stated she worked on the transitional care unit (TCU) during the day shift on 6/12/22. LPN-C stated NA-B informed her that R1 was leaving and that she would be back. LPN-C stated, "I thought that was a normal thing." LPN-C further stated there was no place to chart this information, so she passed it on via verbal report to the oncoming evening nurse (RN-B). LPN-C stated she told RN-B that R1 left with FM-A and thought she would be back that evening but did not know what time R1 would return. LPN-C stated not being aware of any sign out process for residents and did not think R1 would be gone the whole night. When interviewed on 6/16/22, at 3:22 p.m.- SW-A stated she learned about the incident the morning of 6/13/22 and started the investigation immediately. SW-A stated after several attempts to contact R1 and FM-B, she was able to speak to FM-B who confirmed R1 was at home (where she lived prior to being admitted to the facility). SW-A stated she also contacted the police and	F 684			

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F 684	Continued From page 5 requested a welfare check on R1 to ensure she was safe at home. SW-A demonstrated where the sign out book was located and confirmed R1 did not sign out when she left. When interviewed on 6/16/22, at 3:33 p.m. administrator stated staff were aware R1 was leaving to attend a party for FM-A and that staff should have ensured R1 signed out and indicated an expected return time. Administrator stated, "Unfortunately, it [sign out] does not always get done with an expected return." Administrator stated agency staff should receive the information regarding sign out process in their orientation. When interviewed on 6/16/22, at 3:49 p.m. ADON stated the expectation was that the nurse was accountable for their residents and should be suspicious if a resident was not accounted for during a medication pass or at bedtime. ADON stated the nurse should contact administration immediately when a resident was suspected missing. ADON further stated the nurse was expected to write a note in the electronic health record (EHR) to indicate when a resident left the facility, who they left with, how long they would be gone and if they took their medications with them. ADON stated the nurse should also write a note in the EHR when discovered a resident was missing and what action they took. ADON stated RN-B should have investigated R1's absence during 8:00 p.m. medication pass on 6/12/22 and confirmed there were no notes in R1's EHR regarding the outing or the discovery of her absence. ADON stated agency staff normally receive an education packet on their first shift at the facility. When interviewed on 6/16/22, at 4:26 p.m.	F 684			

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F 684	Continued From page 6 interim director of nursing (IDON) stated staff should all have accountability for the residents. IDON stated, "If you are on your shift and you see that a resident is not in the building, you should be calling the resident. You should say-Hey it is 8:00 p.m. time for meds -did you take them with you? Are you coming back?" IDON stated all nurses know if the resident was leaving on LOA (leave of absence), they should fill out a sheet. "I think that day it was the pool nurse's first day in this building, so she did not know the process." IDON further stated RN-A should have called R1 and inquire about her return and that all nurses and NAs should be doing rounds and taking accountability for residents. IDON stated agency nurses were supposed to come in an hour prior to their first shift for an orientation and tour and were shown the incident/accident book. Nurses should be writing notes when there was an incident like this. IDON stated she could not confirm if RN-B completed any orientation. When interviewed on 6/17/22, at 7:54 a.m. RN-C stated she worked the night shift on 6/12/22 on the long-term care (LTC) floor and was also building charge. RN-C stated the nurse working in TCU that night was from an agency and should have been accountable for all the residents on TCU. RN-C further stated not being aware of R1's absence. When interviewed on 6/17/22, at 8:42 a.m.-RN-B stated she worked the evening shift on 6/12/22 and that it was her first shift at that facility. RN-B stated she shadowed LPN-C for 20 to 30 minutes. RN-B stated she took over LPN-C's assignment between 2:30 to 3:00 p.m. RN-B stated she did not receive a packet or any orientation check list. RN-B stated LPN-C had	F 684			

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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) COMPLETION DATE
F 684	Continued From page 7 told her that R1 was gone and did not know when she would return. RN-B stated she looked in R1's room and confirmed R1 was not there and that it appeared there were no personal items. RN-B confirmed she took no further action and marked, "Pt not in room" on the MAR during the 8:00 p.m. medication pass. When re-interviewed on 6/17/22, at 9:42 a.m. LPN-C stated, "Why is everyone calling me? I do not have to keep track of all the residents' whereabouts-when they are coming and going. I have a lot of residents to care for." LPN-C further stated 6/12/22 was her first shift at the facility and she did not receive a packet or orientation check list. LPN-C stated she did show RN-B around prior to the evening shift and gave her the code to the med room. LPN-C stated she told RN-B that R1 was gone and that she, "should be coming back-hopefully." LPN-C stated R1's room looked normal, like she would be coming back. Email received from administrator on 6/17/22, at 9:55 a.m. indicated, "We do not have a signed checklist for [RN-B] or [LPN-C] on file." When interviewed on 6/17/22, at 11:08 a.m. LPN-F stated she worked the night shift of 6/12/22 and that she did not receive report regarding R1's absence from the previous shift. LPN-F stated she has worked in the facility since March or April and had previously worked here in 2019. LPN-F stated never receiving a tour or orientation checklist with her current or previous employment with this facility. The facility Missing Resident/Elopement Process last updated 7/12/21, identified the process staff	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2022
FORM APPROVED
OMB NO. 0938-0391

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 06/17/2022
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F 684	Continued From page 8 should follow once a resident was discovered missing, but did not address accountability for all residents. The Agency Staff Checklist last updated 11/5/21, listed resident care responsibilities, electronic/paper documentation of care, communication, abuse and incident reporting, and administration notification, but did not list details regarding each item.	F 684			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 27, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: F60311

Dear Administrator:

The above facility was surveyed on June 16, 2022 through June 17, 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

Woodlyn Heights Healthcare Center

June 27, 2022

Page 2

"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:

Sarah Grebenc, Unit Supervisor
Metro A 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: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 27, 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 23, 2022, we informed you that we may impose enforcement remedies.

On June 17, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 12, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 12, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 12, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 12, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Woodlyn Heights Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 12, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro A 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: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 9, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

Woodlyn Heights Healthcare Center

June 27, 2022

Page 5

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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized flourish at the end.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 27, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: F60311

Dear Administrator:

The above facility was surveyed on June 16, 2022 through June 17, 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

Woodlyn Heights Healthcare Center

June 27, 2022

Page 2

"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.

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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:

Sarah Grebenc, Unit Supervisor
Metro A 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: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 C 06/17/2022
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
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 6/16/22-6/17/22, 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			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

07/07/22

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 C 06/17/2022
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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H53202297C (MN84279), with licensing order issued at 0830. The following complaint was found to be UNSUBSTANTIATED: H53202298C (MN84333). 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	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 C 06/17/2022
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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			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide proper accountability for 1 of 1 resident (R1) reviewed for leaving the facility for a planned event and did not return. Findings include: R1's admission Minimal Data Set (MDS) dated 6/12/22, indicated R1 admitted to the facility on 6/8/22. R1 required supervision or touching	2 830	Tag 0830 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		7/7/22

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 C 06/17/2022
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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2 830	Continued From page 3 assistance for mobility. R1's diagnoses list printed 6/16/22, included traumatic subarachnoid hemorrhage (brain bleed because of injury), delirium, insomnia, and restlessness and agitation. R1's care plan indicated R1 had an ADL (activities of daily living) self-care deficit with interventions listed assist with dressing/undressing, set up for eating, and preferred wake time of 7:00 a.m. and bedtime of 10:00 p.m. R1's care plan indicated R1 had limited physical mobility and required one staff for assistance with ambulation. R1's care plan indicated R1 had difficulty sleeping and instructed staff to implement sleep log and sleep encouragement techniques. R1's medication administration record (MAR) indicated eight medications were not given on 6/12/22, with a chart code of 5-hold/see progress notes. R1's progress notes dated 6/12/22, at 19:29 p.m. through 22:42 p.m. indicated the eight medications were not given due to, "pt [patient] not in room." R1's progress notes lacked any communication regarding R1 leaving the facility for a planned event with family nor R1's absence on the evening or night shift of 6/12/22. Review of the facility investigation file indicated R1 left the facility on 6/12/22, at 1:30 p.m. with family member (FM)-A to attend a graduation party and would return after the event. The file further indicated R1 did not return the facility which was not discovered until the morning of 6/13/22.	2 830	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 Tag 0830, Adequate and Proper Nursing Care, Woodlyn Heights Senior Living corrected the deficiency by providing 1:1 education to the scheduler on 6/20/22 by the ED/DON on ensuring that agency staff have been educated by using the Agency Staff Checklist. Resident R1 is no longer in facility. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated by 7/7/22 or prior to the start of their next shift on the Leave of Absence process. The DON and/or designee will audit weekly x4 weeks, then 2x a month x1 month, and then PRN 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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2 830	Continued From page 4 When interviewed on 6/16/22, at 9:31 a.m. licensed practical nurse (LPN)-A stated it was very important to know when the resident was expected to return from an outing or appointment. LPN-A further stated, she would call family if the resident had not returned by 30 minutes after their expected return time. LPN-A stated it was important to know how long the resident would be gone and if they needed to take their medications with them. When interviewed on 6/16/22, at 9:51 a.m. nursing assistant (NA)-A stated the standard process would be to receive report from either the nurse or the resident's family regarding when the resident would be expected to return to the facility. NA-A stated it was important to know if the resident would be returning shortly after a meal and would like the meal to be held for them. When interviewed on 6/16/22, at 11:30 a.m. LPN-B stated if a resident was going out with family it should be communicated staff to staff verbally and that the expected return time should be known and passed along. LPN-B further stated she would not let too much time pass after the expected return time to start investigating and would start by calling family. When interviewed on 6/16/22, at 1:18 p.m. NA-B stated she worked with R1 on 6/12/22 and that R1 was ambulatory with a 4-wheel walker. NA-B stated R1 left that day with FM-A and asked to have her dinner saved that evening as she thought she would be back just after dinner. NA-B stated she reported this information to (LPN-C) and told her she need to pass it on to the next shift and enter a note in a communication book. NA-B stated she was right in the middle of	2 830			

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2 830	Continued From page 5 assisting a different resident so she could not walk out with R1, and FM-A. NA-B stated the resident was supposed to sign out in the book at the facility entrance indicating when they left and when they expected to return. NA-B stated she worked the morning of 6/13/22, got report as usual and started answering call lights on the 100 unit. NA-B stated she finally got to R1's room about 7:45 a.m. to deliver a breakfast tray and saw that R1 was not in her room. NA-B stated she immediately inquired with registered nurse (RN)-A who must have notified administration because soon after that social worker (SW-A) and assistant director of nursing (ADON) began questioning her. When interviewed on 6/16/22, at 2:51 p.m. LPN-D stated it was the staff's responsibility to ensure the resident signed out when they left the facility and that the sign out sheets were kept at the nurse's station. LPN-D further stated if for some reason they did not sign out, the staff should get a verbal confirmation from the resident regarding their expected return time and that information should be passed on to the next shift. LPN-D stated she would call the resident or the family to inquire about their expected return if they were gone for too long or over a medication pass. When interviewed on 6/16/22, at 3:00 p.m. LPN-E stated he rounds on all assigned residents at the start of the shift and confirm their presence in the facility. LPN-E stated if unable to find a resident he would first check the appointment book and then the sign out book by the door. LPN-E stated it was important to know the whereabouts of his assigned residents. When interviewed on 6/16/22, at 2:32 p.m. LPN-C stated she worked on the transitional care	2 830			

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2 830	Continued From page 6 unit (TCU) during the day shift on 6/12/22. LPN-C stated NA-B informed her that R1 was leaving and that she would be back. LPN-C stated, "I thought that was a normal thing." LPN-C further stated there was no place to chart this information, so she passed it on via verbal report to the oncoming evening nurse (RN-B). LPN-C stated she told RN-B that R1 left with FM-A and thought she would be back that evening but did not know what time R1 would return. LPN-C stated not being aware of any sign out process for residents and did not think R1 would be gone the whole night. When interviewed on 6/16/22, at 3:22 p.m.- SW-A stated she learned about the incident the morning of 6/13/22 and started the investigation immediately. SW-A stated after several attempts to contact R1 and FM-B, she was able to speak to FM-B who confirmed R1 was at home (where she lived prior to being admitted to the facility). SW-A stated she also contacted the police and requested a welfare check on R1 to ensure she was safe at home. SW-A demonstrated where the sign out book was located and confirmed R1 did not sign out when she left. When interviewed on 6/16/22, at 3:33 p.m. administrator stated staff were aware R1 was leaving to attend a party for FM-A and that staff should have ensured R1 signed out and indicated an expected return time. Administrator stated, "Unfortunately, it [sign out] does not always get done with an expected return." Administrator stated agency staff should receive the information regarding sign out process in their orientation. When interviewed on 6/16/22, at 3:49 p.m. ADON stated the expectation was that the nurse was accountable for their residents and should be	2 830			

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2 830	Continued From page 7 suspicious if a resident was not accounted for during a medication pass or at bedtime. ADON stated the nurse should contact administration immediately when a resident was suspected missing. ADON further stated the nurse was expected to write a note in the electronic health record (EHR) to indicate when a resident left the facility, who they left with, how long they would be gone and if they took their medications with them. ADON stated the nurse should also write a note in the EHR when discovered a resident was missing and what action they took. ADON stated RN-B should have investigated R1's absence during 8:00 p.m. medication pass on 6/12/22 and confirmed there were no notes in R1's EHR regarding the outing or the discovery of her absence. ADON stated agency staff normally receive an education packet on their first shift at the facility. When interviewed on 6/16/22, at 4:26 p.m. interim director of nursing (IDON) stated staff should all have accountability for the residents. IDON stated, "If you are on your shift and you see that a resident is not in the building, you should be calling the resident. You should say-Hey it is 8:00 p.m. time for meds -did you take them with you? Are you coming back?" IDON stated all nurses know if the resident was leaving on LOA (leave of absence), they should fill out a sheet. "I think that day it was the pool nurse's first day in this building, so she did not know the process." IDON further stated RN-A should have called R1 and inquire about her return and that all nurses and NAs should be doing rounds and taking accountability for residents. IDON stated agency nurses were supposed to come in an hour prior to their first shift for an orientation and tour and were shown the incident/accident book. Nurses should be writing notes when there was an incident like	2 830			

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2 830	Continued From page 8 this. IDON stated she could not confirm if RN-B completed any orientation. When interviewed on 6/17/22, at 7:54 a.m. RN-C stated she worked the night shift on 6/12/22 on the long-term care (LTC) floor and was also building charge. RN-C stated the nurse working in TCU that night was from an agency and should have been accountable for all the residents on TCU. RN-C further stated not being aware of R1's absence. When interviewed on 6/17/22, at 8:42 a.m.-RN-B stated she worked the evening shift on 6/12/22 and that it was her first shift at that facility. RN-B stated she shadowed LPN-C for 20 to 30 minutes. RN-B stated she took over LPN-C's assignment between 2:30 to 3:00 p.m. RN-B stated she did not receive a packet or any orientation check list. RN-B stated LPN-C had told her that R1 was gone and did not know when she would return. RN-B stated she looked in R1's room and confirmed R1 was not there and that it appeared there were no personal items. RN-B confirmed she took no further action and marked, "Pt not in room" on the MAR during the 8:00 p.m. medication pass. When re-interviewed on 6/17/22, at 9:42 a.m. LPN-C stated, "Why is everyone calling me? I do not have to keep track of all the residents' whereabouts-when they are coming and going. I have a lot of residents to care for." LPN-C further stated 6/12/22 was her first shift at the facility and she did not receive a packet or orientation check list. LPN-C stated she did show RN-B around prior to the evening shift and gave her the code to the med room. LPN-C stated she told RN-B that R1 was gone and that she, "should be coming back-hopefully." LPN-C stated R1's room looked	2 830			

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2 830	Continued From page 9 normal, like she would be coming back. Email received from administrator on 6/17/22, at 9:55 a.m. indicated, "We do not have a signed checklist for [RN-B] or [LPN-C] on file." When interviewed on 6/17/22, at 11:08 a.m. LPN-F stated she worked the night shift of 6/12/22 and that she did not receive report regarding R1's absence from the previous shift. LPN-F stated she has worked in the facility since March or April and had previously worked here in 2019. LPN-F stated never receiving a tour or orientation checklist with her current or previous employment with this facility. The facility Missing Resident/Elopement Process last updated 7/12/21, identified the process staff should follow once a resident was discovered missing, but did not address accountability for all residents. The Agency Staff Checklist last updated 11/5/21, listed resident care responsibilities, electronic/paper documentation of care, communication, abuse and incident reporting, and administration notification, but did not list details regarding each item. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are accounted for appropriately. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment.	2 830			

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2 830	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			