



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: 2SVZ12

Dear Administrator:

On August 18, 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 July 13, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads '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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 25, 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 informed you that we would be imposing enforcement remedies.

On July 13, 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 actual harm that was not immediate jeopardy (Level G), 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:

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.
- 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:

Annette Winters, Rapid Response Unit Supervisor

Metro 1, Golden Rule 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: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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 CFR § 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.

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)

Woodlyn Heights Healthcare Center

July 25, 2022

Page 5

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/ltr_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



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August 22, 2022

Administrator
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2060 Upper 55th Street East
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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,

A handwritten signature in black ink that reads '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: 245320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/13/2022
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 7/12/22-7/13/22, 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: H53203147C and H53203190C (MN00084714/MN00084842) with deficiencies cited at F677, F693 H53203171C (MN00083949) : with deficiencies cited at F584, F689, F880, H53203170C (MN00084221) with deficiencies cited at F690, F880, H53202947C (MN00084551) with deficiencies cited at F760 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 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584			8/1/22

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

Electronically Signed

TITLE

(X6) DATE

07/28/2022

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 584	Continued From page 1 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 584			
			1. In continuing compliance with F584,		

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F 584	Continued From page 2 review, the facility failed to maintain a safe, homelike, and comfortable environment for 12 of 12 residents reviewed for environmental concerns. In addition, the facility failed to ensure the 200-unit hallway areas and lounge were kept clean and free of garbage and odors, good lighting, and comfortable temperatures. This deficient practice had the potential to affect all residents who utilized these areas. Findings include: The facility grievance reports dated: - 6/27/22, reported concerns of room cleanliness. - 7/6/22, reported concerns of a messy room. On 7/12//22 at 9:05 a.m. during observation when entering the closed double doors of the 200-unit an overwhelming malodorous smell of garbage and feces emanated the air. The hallway and lounge area were observed. Near room 205 was a large red bag open sitting on the floor filled with used disposable food serving containers with uneaten food, open cartons of milk, and cups. Near the room labeled "Hopper" was a clear plastic bag with an incontinent brief soiled with feces and used cleansing wipes sitting on the floor in front of the door. Each of the occupied residents' room had a 36 inch by 25-inch medical waste disposal cardboard box container with red bags inside filled over 10 inches above the top of the box. In the lounge area were five 36 inches by 25 inch medical waste disposal cardboard box container with red bags over full with used yellow gowns, gloves, and mask. Additionally, in the lounge was a large red bag open with used food serving containers, cups, and milk cartons. Continued observation on 7/12/22, 200 unit currently occupied by 12 resident who are in	F 584	Safe/Clean/Comfortable/Homelike Environment, Woodlyn Heights Senior Living corrected the deficiency by contacting the air conditioning vendor and disposing of the garbage on the unit. Administrator had a contactor repair the belt on the 200 unit on 7/21/22. The administrator verified the temperatures have been within normal limits. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 7/28/2022 or prior to their next scheduled shift on maintaining a homelike environment by DON/ADMIN. 3. Audits will be done daily on all units for 2 weeks, then 3 Units 3 times week for two weeks, then 1 Unit 1x per week for 1 month to ensure continued compliance. 4. 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 584	Continued From page 3 quarantine for COVID-19 was found to: " All the lights in the hallway were shut off causing very low light throughout the hallway. " Dirt, gloves, and papers were found lying on the hallway floor. " Four rooms had stacked up hospital bed frames, mattress, bedside stands. " A strong odor of feces, urine, and garbage filled the air. " The residents' room in Unit 200, hallway, and lounge were warm and humid. No air flow from ventilation systems and the large metal industrial fan was not turned on. " Patient lift and sit to stand equipment located on the right side of the hallway. On the left side of the hallway blocking the hand railing was a large covered linen cart, one three tier cart on wheels, and a three-tier cart filled with body soap, lotion, and lotion. A three-tier cart with incontinent products on the top shelf. Three tier carts with a blue pitcher of water. Three-quarters of the handrails were inaccessible throughout the unit due to being blocked by equipment and other items. " All twelve of the occupied residents' room were found to have visible dirt, dust, spill stains from liquids, and garbage. On 7/12/22, at 9:15 a.m. nursing assistant (NA) - B stated, "it is so warm in here, I keep sweating, and the residents had complained about the heat." NA-B further stated, "the nasty smell of garbage just lingers because no one had taken out the garbage". NA-B stated this is not healthy for the residents, especially with the heat and no air flow. NA-B further stated she reported the concerns about the heat on Friday, but no facility staff had come to investigate.	F 584			

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F 584	Continued From page 4 On 7/12/22, at 1:45 p.m. during observation of the 200-unit malodorous smell of garbage filled the hallway and lounge. Found in the lounge were five 36 inches by 25-inch medical waste disposal cardboard box container with red bags over full of used yellow gowns, gloves, and mask. Additionally in the lounge was large red bag filled with used disposable food serving containers with uneaten food, open cartons of milk, and cups. On 7/12/22, at 1:50 p.m. during interview nursing assistant (NA)-B stated she had been the only staff working in this unit except for when the nurse went on the unit to pass medication. NA-B, stated "it smells so bad, and the garbage is piling up, I use the deodorizer to help." NA-B further stated this is not healthy or safe for these residents on this unit. NA-B stated she had not seen housekeeping staff come onto the unit to clean. NA-B further stated, it felt like the other staff avoid this area because it was the COVID-19 unit. On 7/13/22, at 8:33 a.m. during observation of the 200 unit in the hallway outside room 212 was a large red bag opened with found used disposable food serving containers with uneaten food, open cartons of milk, and cups. The facility's TELS Work Order report dated 7/13/22, lacked indication concerns regarding the heat in the 200 unit and the air conditioner not working. On 7/13/22, at 9:12 a.m. Regional Environmental Service Director (ESD) stated the facility did not have a policy for proper containment or removal of garbage. ESD stated housekeeping staff working with the nursing staff should have	F 584			

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

PRINTED: 08/08/2022
FORM APPROVED
OMB NO. 0938-0391

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F 584	Continued From page 5 removed or disposed of the refuse as needed and should not be left in the hallways for health and safety reasons. ESD further stated the facility is using a contracted housekeeping staff and would need to follow up with removing the garbage off the unit. A facility policy was requested none was provided. On 7/13/22, at 2:00 p.m. the director of nursing (DON) stated it is the responsibility of the nursing and housekeeping staff to ensure garbage is removed off the unit and not piled up in the hallways. DON further stated staff should not put open bags of food containers, bags of personal protective equipment, and bags of soiled clothing and towels on the floors in the hallway for health and safety reason. DON further stated her expectations for staff to ensure the hallways are kept free of garbage, and the garbage is removed as needed so it would not pile up. On 7/13/22, at 6:25 p.m. administrator stated she was made aware of the warm temperatures concerns in the 200 unit on 7/8/22. The administrator further stated the HVAC mechanical serviceman assessed the issues with the air conditioning unit on 200 unit and found a broken belt and a blown fuse. A facility policy on safe, clean homelike environment was requested but not received.	F 584			
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677			8/1/22

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

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F 677	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely assistance with incontinence cares for 3 of 3 residents (R1, R2, R5) who required total assistance with checking and changing of incontinence products. Findings include: The facility Grievance logs undated, indicated from 6/24/22, to 7/10/22, ten grievances were filed with the facility. Grievances: - On 6/6/22, indicated a resident had not been checked for three hours. - On 6/28/22, indicated a resident had concerns because he put his call light on to receive pain medications, and 45 minutes later before someone to come. Staff will walk by resident's room with call light on. - On 7/5/22, indicated a resident had been lying in bed wet and appeared no one cleaned at night. Staff complain about being short staff and no one cleaned the bedding until 11:30 a.m. - On 7/6/22, indicated concerns regarding call light on and no one comes, then comes with attitude. No two-hour checks or water and room is messy. - On 7/10/22, indicated concerns regarding call light on since 1:22 p.m., aide stated she would come back but went on break, and finally assisted at 2:45 p.m. R1's care plan dated 6/20/22, indicated R1 had a ADL self-care performance deficit related to pneumonia, and esophageal obstruction and directed staff to assist with dressing, eating, oral care, and toilet use. R1's care plan further	F 677	1. In continuing compliance with F677, ADL Care Provided for Dependent Residents. Woodlyn Heights Senior Living corrected the deficiency by immediately making sure R1, R2, R5, and all like residents were care planned to be check and change 4 x per shift for incontinent cares on 7/13/2022 by Kiara Marshall, Director of Nursing. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 7/28/2022 or prior to their next scheduled shift on providing timely incontinence cares by the DON. 3. The DON and/or designee will audit incontinent cares on 5 residents 3 times a week for 4 weeks, 2 times a week for 2 weeks, and then as needed to ensure continued compliance. 4. 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 677	Continued From page 7 indicated R1 had incontinence of bowel and bladder and directed staff to provide perineal care after incontinent episode, use absorbent pads, and encouraging toileting. R1's admission Minimum Data Set (MDS) dated 6/26/22, indicated R1 was cognitively intact, required extensive assistance for toilet, personal hygiene, and dressing. R1's MDS further indicated R2 had diagnoses of pneumonia, malignant neoplasm (cancer) of pharynx, and COVID-19. R1's activities of daily living Care Area Assessment (CAA) and urinary CAA dated 6/26/22 were triggered and addressed on care plan. R1's call light log dated 7/13/22, indicated R1 call light was on: - for 52 minutes on 7/5/22, at 1:25 p.m. - for 75 minutes on 7/6/22, at 7:21 p.m. - for 46 minutes on 7/7/22, at 5:39 a.m. - for 52 minutes on 7/7/22, at 7:20 a.m. - for 75 minutes on 7/8/22, at 8:13 a.m. - for 79 minutes on 7/8/22, at 7:17 p.m. - for 96 minutes on 7/9/22, at 8:05 a.m. - for 29 minutes on 7/10/22, at 4:53 a.m. - for 82 minutes on 7/10/22, at 10:14 a.m. - for 15 minutes on 7/12/22, at 10:41 a.m. - for 29 minutes on 7/12/22, at 9:13 p.m. On 7/12/22, at 8:55 a.m. R1 was observed lying in his bed with his head of bed up at a 75-degree angle with his incontinent brief unsecured on the right side, and dressed in a hospital gown, eating hot cereal. R1 stated "can you turn the light on in my room while I eat," staff just come in and out so quickly. R1 stated he does not like to use the call	F 677			

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F 677	Continued From page 8 light because he had to wait so long it does not help if he put it on. On 7/12/22, at 1:30 p.m. during observation and interview R1 was observed lying in bed in a soiled with white colored food stain gown, incontinent brief on and was soiled with urine. R1 stated "can you asked them to help me, I had been waiting for more than 25 minutes after the aide told me she would come back." R1 further stated it is uncomfortable. R1's Kardex dated 7/13/22, directed staff to provide perineal care after incontinence care, oral cares, dressing, and bed mobility. R1's Kardex further directed staff apply barrier cream to exposed areas, and to use absorbent briefs that wick and hold moisture. On 7/13/22, at 11:00 a.m. family member (FM)-B stated she had concerns for R1 overall care and how staff were managing cares which included incontinent cares, dressing, and bathing. FM-B stated R1 would put on his call light, and it would be on for over and hour. R1 should not have to wait that long if he needed something especially because he is dependent on staff for his cares. R2's admission Minimum Data Set (MDS) dated 5/31/22, indicated R2 was cognitively intact, required extensive assistance with two staff for toilet use and personal hygiene. R2's MDS further indicated R2 had diagnoses of dissection of thoracic aorta (serious condition in which a tear occurs in the inner layer of the body's main artery (aorta), diabetes, heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and urinary retention (condition in which you cannot empty all the urine from your	F 677			

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F 677	Continued From page 9 bladder). R2's activities of daily living Care Area Assessment (CAA) and urinary CAA dated 5/31/22 were triggered and addressed on care plan. R2's care plan dated 5/25/22, indicated R2 had a limited physical mobility related to fall risk and directed staff to assist with turn and repositioning, and transfers. R2's care plan further indicated R2 had a potential/actual impairment to skin integrity and directed staff to keep skin clean and dry . R2's admission note dated 5/25/22, at 11:14 p.m. indicated R2 was admitted around 4:00 p.m., was incontinent of bowels and had a catheter in place. R2's admission note further indicated R2 required the use of a mechanical lift and had four small open pressure ulcers on the coccyx. R2's Fall Risk summary dated 5/26/22, indicated R2 was a high risk for falls. R2's skilled charting progress note (PN) dated 5/27/22, R2's current functional status was R2 did not bear weight, had an unsteady gate and weakness. R2's PN further indicated R2 had late loss ADL concerns and required assistance with toileting, bed mobility, and transfers. R2's nurse PN dated 5/31/22, indicated FM-A complained of R2 being weak, lethargic, and running a temperature. R2's social worker PN dated 5/31/22, at 9:29 p.m. indicated FM-A was unhappy with the facility regarding how R2 had not been allowed to use the toilet.	F 677			

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F 677	Continued From page 10 During interview on 7/13/22, at 10:52 a.m. R2's family member (FM)-A stated she was very unhappy with the care her mom was receiving at the facility. FM-A further stated the carpet in the hallways was dirty and smelled of old urine. FM-A stated she was concerned her mm had to sit in an incontinent brief soiled and when FM-A put on call light no one would come for more than 20 minutes. FM-A stated her R2 was supposed to be toileted every two hours and that never happened, staff told R2 they would clean her up and left the room. On another occasion, FM-A stated when she had visited R2, R2 had been sitting in feces soiled incontinent brief for more than three hours before staff would change her. FM-A stated she had reported her concerns to the social worker. FM-A stated R2 was admitted to the hospital after she complained regarding a change in condition and R2 developed a urinary tract infection and sepsis. FM-A further stated if the facility staff would have not made R2 wait so long in feces soiled brief R2 would not have gotten an infection. FM-A stated she observed staff dropping the catheter tubing on dirty stained floor and not cleaning afterwards. During interview with social worker (SW) on 7/13/22, at 2:32 p.m. SW stated FM-A had reported concerns regarding R2 care while in the facility but was unable to remember exactly what the concerns were about. R5's annual Minimum Data Set (MDS) dated 2/3/22, indicated R5 was cognitively intact, required extensive assistance of two staff to assist with toilet use and personal hygiene. R5's MDS further indicated R5 was always incontinent of bowel and bladder. R5's MDS indicated R5	F 677			

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F 677	Continued From page 11 had diagnoses of quadriplegia (paralysis from the neck down, including the trunk, legs and arms), urinary tract infection, pressure ulcer stage four in the sacral region (bottom of the spine pressure injury is very deep, reaching into muscle and bone and causing extensive damage), and sepsis (life-threatening complication of an infection). R5's activities of daily living Care Area Assessment (CAA) and urinary CAA dated 2/3/22, were triggered and addressed on care plan. R5's care plan dated 2/4/21, indicated R5 had an ADL self-care deficit related to wrist fracture, multiple sclerosis, weakness, and impaired cognition. R5's care plan indicated R5 required two staff for total assistance for to use toilet. R5's care plan directed staff to check and change every two to three hours and as needed. R5's care plan further indicated R5 was incontinence of bowel and bladder related to multiple sclerosis and functional loss and directed staff to use barrier cream to areas exposed to moisture, encourage toileting, and observe skin during cares. R5's hospital Discharge Summary dated 7/8/22, at 3:31 p.m. indicated R5 had a Complicated UTI (urinary tract infection) with bacteria growth showing E. coli (type of bacteria commonly found in the gastrointestinal (GI) tract) and COVID-19. R5's Discharge summary further indicated R5 was placed on cephalexin (antibiotic) for severe sepsis. R5's nurse PN dated 7/3/22, at 6:24 p.m. indicated R5 was sent to the hospital at 12:30 p.m. for shortness of breath, and increased heart	F 677			

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F 677	Continued From page 12 rate at 133. R5's PN further indicated R5 had positive COVID-19 rapid test. R5's nurse PN dated 7/8/22, at 6:34 p.m. indicated R5 was admitted to the facility after hospitalization related to urosepsis and was on antibiotic therapy. R5's Comprehensive Skin and Positioning PN dated 7/12/22, at 1:09 p.m. indicated R5 current urinary tract infection. R5's nurse progress note (PN) dated 7/12/22, at 10:23 p.m. indicated R5 continued on antibiotics for urosepsis. R5's Kardex dated 7/13/22, indicated R5 required two staff to assist with toileting and directed staff to check and change every two to three hours and as needed. R5's Kardex further directed staff to use barrier cream to areas exposed to moisture. R5's call light log dated 7/13/22, indicated R5 call light was on: - for 43 minutes on 7/11/22, at 4:01 a.m. - for 17 minutes on 7/12/22, at 4:33 a.m. - for 26 minutes on 7/12/22, at 9:29 a.m. - for 19 minutes on 7/12/22, at 12:18 p.m. - for 40 minutes on 7/12/22, at 2:47 p.m. - for 50 minutes on 7/12/22, at 5:30 p.m. - for 41 minutes on 7/13/22, at 8:02 a.m. During observation and interview on 7/12/22 at 8:41 a.m. R5 had her call light on. R5 stated it had been on for over 30 minutes, and she needed to have her incontinent brief change. R5 further stated she had to wait almost every day. R5 stated she becomes uncomfortable lying in a	F 677			

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F 677	Continued From page 13 soiled brief and she was concerned because she had a recent UTI. R5's call light was observed to be on for 35 minutes. During interview on 7/12/22, at 9:25 a.m. nursing assistant (NA)-B stated she was the only one working in the COVID-19 200 unit with 11 residents who all need a lot of assistance. NA-B stated she can only go so fast with everything she needed to do. When interviewed on 7/13/22, at 3:00 p.m. director of nursing (DON) stated, residents call lights should be answered in a timely fashion and could be answered by anyone. The DON stated when the resident puts on a call light it indicates the resident is in need of something and more than 10 minutes is too long. The DON further stated some resident had voiced concerns regarding long call lights.	F 677			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the 200-unit	F 689	1. In continuing compliance with F689, Free of Accident		8/1/22

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F 689	Continued From page 14 cleaning chemicals were secured away in a locked cabinet or cart, which had the potential to affect 5 of 12 residents who resided on the 200 unit and could access the hallway. Findings include: On 7/12/22, at 9:05 a.m. - 9:45 a.m. during observation on the 200-unit hallway, a three-quarter full bottle labeled Truekleen Enzymatic Foul Odor Digester, a half full container of Flexo Products AirX 75 - Disinfectant Spray and Wipe Cleaner we're sitting on the handrail in the hallway near room 207 unsecured. One resident was observed sitting in a chair within three feet of where the chemicals were on the railing. No staff were observed in the hallway from 9:05 a.m. to 9:15 a.m. during this observation. Truekleen Enzymatic Foul Odor Digester material safety data sheet (MSDS) dated 4/28/15, indicated it may cause skin and eye irritation and recommended to wear eye protection and gloves when handled. Flexo Products AirX 75 - Disinfectant Spray and Wipe Cleaner MSDS dated 4/2/20, indicated AirX75 was harmful if ingested, contact with skin or eyes, or if inhaled. MSDS recommended to seek medical attention. MSDS further recommended to wear eye goggles, clothing protector, and chemical resistant gloves when handling AirX75. On 7/12/22, at 9:25 a.m. nursing assistant (NA) -B stated the chemicals had been sitting on the railing when she came into work for her shift. NA-B stated she is the only one working in the	F 689	Hazards/Supervision/Devices, Woodlyn Heights Healthcare Center corrected the deficiency by removing the chemicals located in the 200-hallway on 7/13/2022. All other hallways were audited on 7/13/2022 to ensure environment was free from hazards. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 7/28/2022 or prior to their next scheduled shift on proper storage of chemicals by the Director of Nursing and/or Administrator. 3. The Administrator and/or designee will audit all hallways for proper storage of chemicals daily for 4 weeks, then weekly for 1 month and then PRN to ensure continued compliance. 4. As part of Woodlyn Heights Healthcare Center's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.		

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F 689	Continued From page 15 unit right now and the nurse only came in to pass medication. NA-A stated it was hard for her to monitor the resident and it was a concern for accidental swallowing the chemicals. On 7/12/22, at 11:45 a.m. during observation on the 200-unit hallway, a three-quarter full bottle labeled Truekleen Enzymatic Foul Odor Digester, a half full container of Flexo Products AirX 75 - Disinfectant Spray and Wipe Cleaner we're sitting on the handrail in the hallway near room 207 unsecured. On 7/13/22, at 8:33 a.m. during on the 200-unit hallway, a three-quarter full bottle labeled Truekleen Enzymatic Foul Odor Digester, a half full container of Flexo Products AirX 75 - Disinfectant Spray and Wipe Cleaner we're sitting on the handrail in the hallway near room 207 unsecured. Nursing assistant (NA)-B verified the chemicals were unsecured where resident could come into the hallway and some of the residents are able to independent with mobility and had memory loss. On 7/13/22, at 8:35 a.m. registered nurse (RN)-B, stated the cleaners should not have been left in the unsecured anywhere on the 200 unit. He further stated 200 unit had a few residents with cognitive impairment and who are independently ambulatory and could have accidentally ingested the chemicals. On 7/13/22, at 9:12 a.m. the regional environmental service director stated his expectation for staff was to never leave chemicals unsecured where residents may have access because of the risk for accidental ingestion.	F 689			

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F 689	Continued From page 16	F 689			
F 690 SS=E	On 7/13/22, at 2:10 p.m. the director of nursing (DON) stated her expectation would be all chemicals be stored properly per the storage guidelines. DON further stated chemicals should not be stored on the handrail where residents could access the chemicals because the risk for a resident accidentally ingesting or spilling chemicals on themselves. DON further stated the responsibility of all staff properly store chemicals after they are done using them. The facility policy Hazard Communication Program dated 4/19/22, indicated the facility would comply with health and safety rules. 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	F 690			8/1/22

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F 690	Continued From page 17 demonstrates that catheterization is necessary; and (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 failed to ensure a urinary drainage bag and catheter tubing was kept off the floor to prevent cross contamination and potential infection for 5 of 5 residents (R2, R3, R6, R7, R8) reviewed for catheters. Findings include: R2's annual care area assessment (CAA) dated 10/8/21, indicated R2's had a urinary catheter. R2's hospital discharge summary dated 5/24/22, indicated R2 was seen by Urology it was recommended a catheter be placed for urinary retention. Urology recommended weekly removal of the foley catheter for voiding trails until seen again by urology. R2's care plan dated 5/25/22, indicated R2 had an indwelling catheter related to cover catheter bag at all times, catheter cares twice daily, and check tubing, during rounds, and as needed.	F 690	1. In continuing compliance with F690, Bowel/Bladder Incontinence, Catheter, UTI, Woodlyn Heights Senior Living corrected the deficiency by providing immediate education to NA-B appropriate placement of catheter bags and tubing on 7/13/2022 by DON. The Director of Nursing audited all residents with catheter bags and tubing to ensure appropriate on 7/13/2022. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 7/28/2022 or prior to their next scheduled shift on the appropriate placement of catheter bags and tubing. 3. The DON and/or designee will audit placement of catheter bags and tubing 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 18 R2's admission Minimum Data Set (MDS) dated 5/31/22, indicated R2 was cognitively intact and required extensive assistance with toilet use. R2 had diagnosis which included urinary retention, diabetes, and heart failure (chronic condition in which the heart doesn't pump blood as well as it should). R2's physician orders dated 5/31/22, directed staff to monitor catheter insertion site for signs and symptoms of infection or trauma and report changes to doctor every shift. R2's orders further indicated R2 had an indwelling urinary catheter, and directed staff to change as needed for infection, obstruction, or compromised closed system. R2's physician order lacked indication what French (Fr) size or balloon size to be used. R2's nurse progress note (PN) dated 5/31/22, indicated family member called regarding concerns of R2 being weak, lethargic, and running a fever. FM requested R2 be sent to the hospital for evaluation. R2's social service progress notes dated 5/31/22, 9:29 p.m. indicated family member was unhappy with the facility. FM reported concerns about how R2 was not allowed to use the toilet since she was admitted to the facility. During interview on 7/13/22, at 1100 a.m. family member (FM)-A stated she had been at the facility every day from 8:30 a.m. to 8:00 p.m. and observed R2's catheter bag to be left on the floor while. FM-A stated R2's floor was dirty with paper, dirt, dust, and room smelt of urine. R3's care plan dated 12/27/18, indicated R3 had	F 690	4. 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 690	Continued From page 19 an indwelling catheter related to chronic BPH and obstructive reflux uropathy. R3's care plan further indicated R3 had a Conveen closed catheter system. R3's care plan directed staff to observe for signs and symptoms of infection, and cover catheter bag. R3's care plan lacked directions the catheter bag should be kept off of ground. R3's annual care area assessment (CAA) dated 10/8/21, indicated R3's had a urinary catheter. R3's quarterly Minimum Data Set (MDS) dated 4/4/22, indicated R3 was cognitively intact and required extensive assistance with toilet use. R3 had diagnosis which included benign prostatic hyperplasia (BPH) with hyperplasia with lower urinary tract symptoms (enlarged prostate gland), atrial fibrillation (AFIB) irregular and often very rapid heart rhythm (arrhythmia), congestive heart failure (CHF) chronic progressive condition that affects the pumping power of your heart muscle). R3's progress note (PN) dated 6/1/22, at 2:31 p.m. R3 had refused to get out of bed after he was initially got up in the morning to take his shower. R3's PN further indicted R3 had a very poor appetite and weight was down to 200.5 pounds. R3's PN dated 6/6/22, indicated R3 was lethargic, disorientated times four, no urine output since morning per report for previous shift. R3's vital signs were oxygen saturations were 86 percent on two liters per minute via nasal cannula (normal pulse oximeter reading for your oxygen saturation level is between 95% and 100%), blood pressure 153 over 83 (Normal blood pressure for most adults is defined as a systolic pressure of less	F 690			

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F 690	Continued From page 20 than 120 and a diastolic pressure of less than 80), heart rate 47 beats per minute (normal pulse for healthy adults ranges from 60 to 100 beats per minute). R3's PN further indicated R3 verbalized "I am really weak." R3's physician orders dated 6/7/22, indicated R3 had an indwelling urinary catheter 16 French (Fr) / 10 cc balloon for obstructive and reflux uropathy. On 7/13/22, at 1:53 p.m. family member (FM) -C stated R3 had serious heart issues and ended up getting an infection from his catheter which sent him to the hospital. FM-A stated when she had visited on different occasions throughout R3's stays at the facility she had observed the catheter bag and emptying spout with no cap on just lying and dragging on the dirty floor. FM-C stated R3 was sent to the hospital and was diagnoses with urinary tract infection and fluid around his heart. FM-C further stated R3 had passed away related to is infection. FM-C stated she felt the facility had been neglectful of R3's catheter cares and changing it properly. R6's care plan dated 6/20/22, indicated R6 had a supra pubic catheter and directed staff to cover catheter bag all the time, catheter cares twice a day, check tubing for kinks during rounds and as needed. R6's care plan lacked directions the catheter bag should be kept off of ground. R6's nurse PN dated 6/20/22, indicated R6 was admitted to the facility on 6/20/22, at 3:45 p.m. from the hospital due to urinary tract infection (UTI) infection in any part of the urinary system) and encephalopathy (disease in which the functioning of the brain is affected by some agent	F 690			

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F 690	Continued From page 21 or condition (such as viral infection or toxins in the blood). R6's PN further indicated R6 had a suprapubic catheter (surgically created connection between the urinary bladder). R6's physician PN dated 6/23/22, indicated R6 had a long-term status post catheter due to urinary retention and atony and frequent UTI's. R6's admission MDS dated 6/26/22, indicated R6 had moderate cognitive impairment and required extensive assistance to use the toilet. R6's diagnoses included Parkinson's disease, COVID-19, epilepsy, and BPH. R6's care area assessment (CAA) 6/26/22, indicated R6's had a urinary catheter. R6's physician orders dated 7/7/22, directed staff to provide indwelling catheter cares every shift and change indwelling catheter monthly, as needed for infection, obstruction, or compromised closed system. R6's orders lacked indication for use or size of catheter. R6's treatment administration record (TAR) dated 7/22, had an indwelling urinary catheter changed on 7/12/22. R6's TAR further indicated R6 had catheter care completed every shift started on 7/7/22, at night shift. R6's Kardex dated 7/13/22, directed staff to keep urinal at bedside and staff to empty as needed. R6's Kardex lacked indication R6 had a suprapubic catheter or direction for staff to empty catheter. During observation on 7/12/22, at 9:00 a.m. R6 was noted to have a urinary catheter overnight	F 690			

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F 690	Continued From page 22 bag lying directly on the floor with visibly dirty black, brown dried stains and dirt. During observation and interview on 7/13/22, at 9:23 a.m. director of nursing (DON) verified R6 was noted to have a urinary catheter overnight bag lying directly on the floor with visibly dirty black, brown dried stains and dirt. The DON stated the catheter bag should be hung on the side of the bed off the floor while R6 was in bed, "this can put the resident was at risk for getting an UTI. R7's care plan dated 5/27/22, indicated R7 had an indwelling catheter for diagnosis of BPH. R7's care plan directed staff to provide catheter cares twice a day, cover bag at all times, and check for kinks in tubing during rounds and as needed. R7's care plan lacked directions the catheter bag should be kept off ground. R7's care plan further lacked indication R7 preferred to only use a leg bag or provide direction to staff to ensure R7 leg bag was lower than the resident or R7 did not lay on the bag. R7's significant change in status MDS dated 6/20/22, indicated R7 had mild cognitive impairment and required extensive assistance to use the toilet. R7's MDS further indicated R7 had diagnoses which included Parkinson's disease and BPH. R7's care area assessment (CAA) dated 6/20/22, indicated R7's had a urinary catheter. R7's physician orders dated 7/22, indicated an order for a urinary analysis and urine culture was placed to rule out UTI.	F 690			

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F 690	Continued From page 23 The facility surveillance of antibiotic and infection printed on 7/1/22, indicated R7 was treated for a UTI. R7's medication administration record (MAR) dated 7/22, indicated R7's was given doxycycline 100 mg by mouth twice a day for a UTI and aspiration pneumonia started on 7/5/22. R7's TAR dated 7/22, indicated R7 had Conveen catheter bag and directed staff to empty every shift and as needed. R7's TAR directed staff to change catheter bag when the catheter bag was changed. R7's Kardex dated 7/13/22, indicated R7 required two staff to assist with toileting, and use absorbent ads to wick and hold moisture. R7's Kardex lacked indication R7 had a catheter or required catheter cares. During observation on 7/12/22, at 9:30 a.m. R7 was noted to have a urinary leg bag attached to his right leg, R7 was observed lying in his bed on his right side directly on top of his urinary leg catheter bag. R7's catheter connection tubing to the leg bag and dark yellow urine with sediment and the collection bag was found to be more than half full of dark colored urine. During observation on 7/13/22, at 8:30 a.m. R7 was noted to have a urinary leg bag attached to his right leg, R7 was observed lying in his bed on his right side directly on top of his urinary leg catheter bag. R7's catheter connection tubing to the leg bag and dark yellow urine with sediment filled the tubing. R8's hospital discharge summary dated 5/27/21,	F 690			

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F 690	Continued From page 24 indicated R8 had diagnoses of septic shock (infection causing organ failure and dangerously low blood pressure) and urinary tract infection. R8's care plan dated 9/27/21, indicated R8 had a suprapubic catheter related to urinary retention secondary to BPH. R8's care plan directed staff to catheter bag cover used at all times, catheter cares twice a day, change catheter bag every 14 days and as needed for leaking, balloon change monthly and as needed if plugged, site care daily, check for incontinence every two hours, check tubing for kinks during rounds and as needed, and monitor for signs and symptoms of UTI. R8's significant change in status MDS dated 10/15/21, indicated R8 had moderate cognitive impairment, and required extensive assistance to use the toilet. R8's MDS further indicated R8, had diagnoses chronic obstructive pulmonary disease (COPD) lung diseases that block airflow and make it difficult to breathe), BPH, chronic kidney disease stage (CKD) your kidneys are damaged and can't filter blood the way they should). R8's care area assessment (CAA) 10/15/21, indicated R8's had a urinary catheter. R8's physician orders dated 7/8/22, directed staff for R8's supra pubic catheter to change monthly and as needed for plugged or bypassing. R8's order lacked indication of size of Fr or cc of balloon to use. R8's Kardex dated 7/13/22, directed staff to assist of one on and off toilet. R8's Kardex lacked indication R8 had a suprapubic catheter or direction for staff to empty catheter.	F 690			

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F 690	Continued From page 25 During observation on 7/12/22, at 9:33 a.m. R8 was noted to have a urinary catheter overnight bag lying directly on the floor with visibly dirty black, brown dried stains and dirt. During observation on 7/13/22, at 8:45 a.m. R8 was noted to have a urinary catheter overnight bag lying directly on the floor with visibly dirty black, brown dried stains and dirt. On 7/13/22, at 2:30 p.m. infection preventionist stated she had noted some UTI in residents with urinary catheter. She further stated when the catheter bag laid on a dirty floor could put residents at risk for infection. On 07/13/22, at 9:45 a.m. the DON stated catheters needed to be hooked on a side of bed whenever a resident was in bed and off the floor. The DON added if a resident's bed needed to be in the lowest position, residents should not lay on top of the catheter bag to block the flow of urine, and the urinary drainage bag should not be touching the floor to reduce risk of infection. The facility Competency for Catheter dated 5/11/21, directed staff to hang the bag from the bed frame. A facility policy on management of urinary catheter was requested but not received.	F 690			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 693			8/1/22

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F 693	Continued From page 26 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure G-tube placement were checked prior to water flushes and G-tube supplies were replaced every 24 hours for 1 of 1 (R1) reviewed with a G-tube. Findings include: R1's care plan dated 6/20/22, indicated R1 had tube feeding related to dysphagia and history of throat cancer. R1's care plan directed staff to administer tube feeding and water flushes as ordered. R1's care plan lacked indication staff should check for placement prior to administration tube feeding and water flushes. R1's nutritional assessment dated 6/21/22, indicated R1 had no swallowing disorders. R1's nutritional assessment further indicated R1 had	F 693	1. In continuing compliance with F693, Tube Feeding Management/Restore Eating Skills. Woodlyn Heights Senior Living corrected the deficiency by immediately replacing, labeling, and dating R1 and all like resident's tube feeding equipment on 7/13/2022. An order was placed in R1 TAR to check G-tube placement prior to water flushes and administration of tube feeding on 7/25/2022. All other like residents were assessed on 7/25/2022 to ensure tube feeding placement orders were in TAR. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 7/28/2022 or prior to their next scheduled shift on Enteral Feeding: Verifying Tube Placement Policy		

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F 693	Continued From page 27 G-tube. R1's physician initial intake progress note (PN) dated 6/23/22, indicated R1 had a hospitalization from 6/15/22, to 6/20/22, for pneumonia. R1's PN further indicated R1 had a video swallow with speech therapist on 6/16/22, which indicated frank aspiration with delayed cough reflux was found with thin consistency swallow. On 6/15/22, R1's chest X-ray while in the hospital indicated R1 had developed atypical pneumonia and was diagnosed with aspiration pneumonia. R1's admission Minimum Data Set (MDS) dated 6/26/22, indicated diagnoses that included esophageal obstruction (abnormal tightening or narrowing of the esophagus), esophagitis (Inflammation that damages the tube running from the throat to the stomach (esophagus), malignant neoplasm of pharynx (cancer of throat), pneumonia (infection in lungs), and adult failure to thrive. The MDS indicated R1 received tube feedings. R1's care area assessment (CAA) dated 6/26/22, indicated R1 received more than 51 percent of total calories by tube feeding and received more than 501 ml of fluid by mouth daily. R1's treatment administration record (TAR) dated 7/1/22, directed staff to clean tube feeding pump and pole every night shift and change and date bag, tubing, syringe, and piston every night. R1's TAR lacked direction for staff to check placement prior to administration of tube feeding and water flushes. R1's nurse practitioner (NP) PN dated 7/3/22, indicated R1 physical exam demonstrated coarse	F 693	& Procedure along with replacing and labeling tube feeding supplies by DON. 3. The DON and/or designee will audit tube feeding administration along with equipment for appropriate labels/dates on all residents with tube feeding 3 times a week for 4 weeks, then 2 times a week for 2 weeks, and then PRN to ensure continued compliance. 4. 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 693	Continued From page 28 crackles at lung bases bilaterally. R1's nurse progress note (PN) dated 7/5/22, indicated R1 tube feeding was beeping on and off. R1's nurse PN dated 7/10/22, at 9:56 p.m. indicated R1's G-tube had blown. PN further indicated the physician stated it needed to be changed and would be best to be done on Monday. R1's nurse PN dated 7/11/22, 9:17 a.m. indicated R1 had returned from the hospital with new G-tube placement. R1's speech therapy (SP) PN dated 7/13/22, indicated R1 had precautions of aspiration risk, was on a pureed diet, and R1 had a G-tube. R1's physician orders dated 7/13/22, indicated R1 had orders for: - Elevate the head of bed at least 30-45 degrees while tube feeding is running every shift. - Flush G-tube (type of feeding tube) with 150 ml of water every four hours for G-tube flushing. - Isosource 1.5 cal 60 ml/hour. Stop feedings at 5:00 a.m. for nutritional support. - Tube feeding cleaning: clean tube feeding pump and pole every night. - Tube feeding equipment change: Change and date bag, tubing, syringe, and piston every night shift. On 7/12/22, at 8:40 a.m. during observation in R1's room was a graduated cylinder and syringe dated 6/22/22. Registered nurse (RN)-A stated she used the graduated cylinder and syringe to give R1 his water flushes this morning. RN-A	F 693			

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F 693	Continued From page 29 acknowledged the date of 6/22/22, and stated it should be changed once a day. RN -A did not respond when asked why the date of 6/22/22, was on the cylinder or if she had gotten a new one during her shift. On 7/13/22, at 12:00 p.m. R1 was observed lying on his bed. RN- B indicated R1 was due for water flushes per the physician's order. At 12:05 p.m. RN-B retrieved the graduated cylinder and syringe and filled the graduated cylinder up with 175 milliliters (ml) of water. RN-B attached the syringe to the port of the G-tube and proceeded to pour the water in to the syringe allowing the water to instill by gravity without checking for placement. RN-B repeated the process three times. R1 garbage can had a graduated cylinder dated 6/22/22, with a syringe. On 7/13/22 at 12:10 p.m. RN-B acknowledged he had not checked the G-tube placement prior to administering the water flushes. RN-B stated R1 did not have an order to check placement before giving water flushes. RN-B further stated placement should be checked prior to medication, water flushes, or administering tube feeding. RN-B stated he noticed the graduate cylinder and syringe R1 had in his room which was used for water flushes was dated 6/22/22, and he threw it away because it should be changed every 24 hours. RN -B further stated reusing the graduate cylinder and syringe for longer than 24 hours could harbor bacteria and increase the risk for infection. On 7/13/22, at 11:00 a.m. family member (FM)-B stated she had concerns for R1 and how staff were managing cares for R1 G-tube. FM-B stated R1 G-tube was reported to her as "blown" and	F 693			

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F 693	Continued From page 30 was sent to the hospital for a replacement. On 7/13/22, at 2:56 p.m. nurse practitioner (NP)-A stated nursing staff should ensure that the tube is located in the stomach. NP-A stated R1 had COVID-19 and had been coughing which could cause the G-tube to move from the correct placement. On 7/13/22, at 2:07 p.m. the director of nursing (DON) stated she expected tube placement to be checked prior to administering medications, water flushes, and tube feedings. DON further stated the graduate cylinder and syringe should be replaced every 24 hours and is indicated on the orders. The facility policy Enteral Tube revision date 3/12/14, directed staff to check placement by drawing up 10-15 cubic centimeter cc (of air in a 60-cc piston syringe, listen with stethoscope and inject the 10-15 cc of air into the port G-tube feeding port, and listen for a gurgle noise. The policy further directed staff to than pull back on syringe and exam for stomach contents. The facility policy directed staff to check for placement prior to administering fluids via G-tube.	F 693			
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a system for accurate transcription of physician and	F 760	1. In continuing compliance with F760, Residents are Free of Significant Med Errors. Woodlyn Heights Senior Living		8/1/22

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F 760	Continued From page 31 medication orders for 1 of 1 residents (R4) with a history of congestive heart failure (CHF) who had medication omitted for 26 days, was subsequently hospitalized, and had a decline in activities of daily living (ADLs) as a result of the missed administration of medication resulting in harm. The facility further failed to ensure an International Normalized Ratio (INR a standard lab test used when taking blood-thinning medications) result was sent to the provider and obtained per physician order for coumadin. The facility failed to administer coumadin (a blood-thinning medication) per the INR level for nine (9) days for 1 of 1 (R9) residents reviewed for coumadin use. Findings include: R4's care plan dated 11/12/21, indicated R4 had an altered cardiovascular status related to cerebrovascular accident (CVA) loss of blood flow to part of the brain, which damages brain tissue), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and hypertension (HTN) high blood pressure. R4's care plan directed staff to observe, document, and report to medical practitioner as needed any signs of symptoms of altered cardiac output or pacemaker malfunction such as dizziness, syncope, difficulty breathing, pulse rate lower than programmed rate, or lower than base line blood pressure. R4's significant change status Minimum Data Set (MDS) dated 5/2/22, indicated R4 had severe cognitive impairment and had diagnoses of stroke, heart failure, hypertension, diabetes, and	F 760	corrected the deficiency by immediately providing education to nursing staff regarding processing of orders for R4 on 7/7/22 and immediately educated nurse on Coumadin INR process for R9 and all like residents. All resident charts were reviewed for accuracy of orders. This was completed by the Regional Clinical Quality Specialist by 6/30/2022. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 7/28/2022 or prior to their next scheduled shift on processing orders by the DON/ADON or designee. 3. The ADON and/or DON will audit all new orders for accuracy 5 times a week for 4 weeks, 2 times a week for 2 weeks, and then as needed to ensure compliance. 4. 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 760	Continued From page 32 COPD. R4's medication administration record (MAR) dated 5/22, indicated R4 was given one dose of furosemide 40 mg for diastolic heart failure on 5/27/22. R4's MAR lacked indication R4 was given from 5/28/22, to 5/31/22, which was a total of 4 days of furosemide was missed. R4's hospital discharge orders dated 5/27/22, indicated R4 had a medication regimen change with furosemide 40 mg tablet every morning was added for HF chronicity. The hospital discharge orders lacked indicated a second check was completed by another nurse because of the lack of signature. R4's primary nurse practitioner (NP) admission to facility note dated 5/31/22, indicated R4's weight on 5/27/22, at 7:00 a.m. R4 weighed 121 lbs 9.6 oz. R4's was observed to be seated in her chair wearing four (4) liters of oxygen. Weight was 5/31/22, at the facility was 131 pounds. R4's dietary PN dated 6/1/22. at 11:37 p.m. indicated R4's current weight was 131.5 pounds. R4's NP's progress note dated 6/13/22, weight 128.4 lbs. Oxygen saturation (O2 sat) were 94 percent on room air. PN's indicated not on Lasix, weight is up, and had new edema. PN further indicated plan to add Lasix 10 mg daily. R4's PN dated 6/17/22, at 4:42 p.m. indicated to monitor R4 for signs and symptoms of fluid overload due to recent weight gain. R4's MAR dated 6/22, indicated R4 had no doses of furosemide were given to R4 from 6/1/22 to	F 760			

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F 760	Continued From page 33 6/22/22, which was a total of 22 days of furosemide was missed. R4' weight summary indicated R4 weights: - On 6/1/22, R4's weight was 131 lbs. - On 6/3/22, R4's weight was 125 lbs. - On 6/4/22, R4's weight was 125 lbs. - On 6/9/22, R4's weight was 128.4 lbs. - On 6/14/22, R4's weight was 130.6 lbs. - On 6/16/22, R4's weight was 135 lbs. - On 6/17/22, R4's weight was 142 lbs. - On 6/18/22, R4's weight was 143 lbs. - On 6/19/22, at 10:24 a.m. R4's weight was 143.2 lbs. - On 6/19/22, at 12:27 p.m. R4's weight was 144 lbs. - On 6/20/22, p.m. R4 weight 142.6 lbs. R4's weight log lacked indication staff weighed R4 daily. R4's PN dated 6/22/22, at 11:02 p.m. indicated R4 was found to have shortness of breath, wheezing was audible on inhalation and expiration. Crackles heard in left lower mid lung with wheezes bilaterally in lungs. Orders received to send R4 to emergency room. R4's hospital Admission History and Physical dated 6/22/22, at 3:39 p.m. indicated R4 was sent to the emergency room for evaluation of shortness of breath from the facility. R4 was admitted to the hospital for treatment of her CHF and underwent a right-side thoracentesis. The report indicated R4 was discharged from a previous hospitalization to the facility on 5/27/22, but R4 reported she had progressively got shorter of breath and wheezing. R4's H&P indicated R4 abdomen was bloated and R4 reported she felt	F 760			

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F 760	Continued From page 34 like she had gained quite a bit of weight, and significant lower extremity edema. R4 further reported to the hospital staff, when she was talking to family member (FM) -E, FM-E noted she sounded "terrible". Her weight was documented at 144 pounds (lb) 6.4 ounces (oz). R4 echocardiogram demonstrated pleural effusion. R4's primary diagnosis for her hospital admission was acute on chronic diastolic heart failure and per pharmacy records R4 had not been receiving the furosemide she was ordered on 5/27/22, from her last hospitalization. R4 received 40 milligrams (mg) intravenous furosemide in the emergency room and 40 mgs every eight (8) hours and a thoracentesis. R4's hospital discharge summary 7/1/22, indicated R4 was hospitalized from 6/22/22 to 7/1/22, for the diagnoses of acute on chronic diastolic heart failure (acute heart failure is a sudden, life-threatening condition in which the heart is unable to do its job.) R4's admission nurse PN dated 7/1/22, indicated R4's weight was 122.4 lbs was 124 lbs. R4's Kardex dated 7/13/22, directed staff to obtain weight. On 7/12/22, at 11:14 a.m. during interview family member (FM)-E, stated she had concerns regarding her mom's care and how the facility missed a physician's order for so long to cause R4 to be admitted to the hospital for something avoidable. On 7/12/22, at 1:17 p.m. registered nurse (RN)-C stated orders should be placed into the electronic medical record first, then the paper orders are	F 760			

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F 760	Continued From page 35 placed on the shelf in the nurse's station for the next shift to complete a second check. The second check nurse would put their initials on the paper orders once reviewed. On 7/12/22, at 1:30 p.m. during interview with licensed practical nurse (LPN)-D stated the order processed is "messed up" and had changed recently. She further stated orders are sometimes placed anywhere in the chart rather than in the order section of the hard chart. LPN-D stated she is unsure of what the process for orders was and had seen orders get missed recently with another error of a resident not receiving medication. On 7/12/22, at 2:57 p.m. RN - B stated when we receive an order we enter into the electronic health record, put the order into the hard chart, and put out the red flag, set on the shelf for the next shift to review and sign off on. RN-B stated the orders should be put in the orders tab in the hard chart. On 7/12/22, at 5:30 p.m. nurse practitioner (NP) - A stated R4's recent hospitalization was directly correlated to not receiving her Lasix 40 mg as ordered from her previous hospital discharge. NP-a further stated R4 could have avoided having a hospitalization and thoracentesis if Lasix was given as ordered, follow up with assessment such as monitoring for edema and weights. NP-A stated R4 was medically complex and a brittle diabetic who needed to be managed carefully. NP-A further stated she is unsure of what happened other than a transcription error. On 7/13/22, at 12:17 p.m. when interviewed the director of nursing (DON) stated the admitting nurse transcribed the order wrong into the	F 760			

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F 760	Continued From page 36 electronic health record. She further stated there was no second check completed to verify the order was entered correctly. DON further stated on 5/24/22, the process for entering orders changed from the health unit coordinator starting the process of entering the order into the electronic health record, reviewed by the nurse to sign off on. The facility changed the process to using a two step nurse review to sign off. The DON stated the staff were educated by the interim DON while she was out on leave and verified not all staff including agency were educated on the entering order process. DON further stated her expectation for staff would be to follow provider order and policy/procedure. On 7/13/22, at 4:50 p.m. when interviewed consulting pharmacist stated it was serious concern and significant medication error for R4 not to receive her furosemide 40 mg for her congestive heart failure for 22 days causing her to be admitted into the hospital. Consulting pharmacist stated he was not notified of the medication error but should be reviewed at the QAPI meeting. On 7/13/22, at 4:50 p.m. when interviewed consulting pharmacist stated it was serious concern and significant medication error for R4 not to received her furosemide 40 mg for her congestive heart failure for 22 days causing her to be admitted into the hospital. Consulting pharmacist stated he was not notified of the medication error but should be reviewed at the QAPI meeting. The facility policy on standing orders dated 1/17/22, directed staff for heart failure management to" - Obtain daily weights. - For weight gain of greater than two and half	F 760			

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F 760	Continued From page 37 pounds in 48 hours, or five pounds above admission weight. - Assess lung sounds, peripheral edema, and respiratory effort daily. R9's hospital Transfer Orders dated 4/22/22, indicated R9 was to take Warfarin 3 mg daily for atrial fibrillation (A-Fib). R9's care plan dated 4/22/22, indicated R9 had an alteration in hematological status and directed staff to administer medication as ordered, observe for side effects, and report any complications. R9's care plan further directed staff to obtain lab and diagnostic work as order and report results to the provider as indicated. R9's significant change in status MDS dated 5/11/22, indicated R9 was cognitively intact and had diagnoses which included fracture of lumbar vertebra and atrial fibrillation. R9's MDS further indicated R9 required extensive assistance from two staff for activities of daily (ADL's) which included bed mobility and transfers. R9's MDS indicated R9 had impairment on one side of her upper extremity and both lower extremities. R9's Order Summary dated 7/13/22, lacked indication R9 was on coumadin (medication is used to treat or prevent blood clots) and anticoagulant (blood thinner). R9's medication administration record (MAR) dated 7/22, indicated R9 had an order for: - Warfarin sodium tablet three (3) mg one time a day at 6:00 p.m. on 7/9/22, through 7/11/22. - On 7/12/22, Coumadin use: Resident is on coumadin and directed staff if no active coumadin orders to follow up with provider and laboratory	F 760			

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F 760	Continued From page 38 for orders, every shift. R9's MAR dated 7/22, lacked indication R9 received coumadin from 7/1/22 to 7/9/22. Medication Error Incident report dated 7/11/22, indicated on 7/9/22, it was discovered nursing staff had not processed the INR lab draw that was done on 6/30/22, and staff did not contact the provider to get new coumadin orders for the resident. R9's incident report indicated interdisciplinary team (IDT) reviewed the medication error. The root cause for R9's medication error was related to failure to complete INR/coumadin process. A nurse reported she was not aware R9 received coumadin due to no order being on R9's MAR. A coumadin use alert was added to the resident MAR to alert R9 took coumadin. R9's medication error incident report lacked indication education was completed to staff after this incident occurred. R9's treatment administration record (MAR) dated 7/22, directed staff to check an INR on 7/13/22 and call provider with results. R9's Anti-Coagulant Flow Sheet undated, indicated R9 had A-Fib, and on 6/30/22, R3 had a current dose of coumadin 3 mg daily with an INR of 4.45 with new dose to be coumadin 3 mg daily until 7/13/22. R9's Flow Sheet further directed staff to recheck INR on 7/13/22. On 7/13/22 R9's INR was 1.34. On 7/13/22, at 2:00 p.m. the DON stated another medication error occurred for R9 and R9 did not receive coumadin for many days because nursing staff did not complete the medication order	F 760			

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F 760	Continued From page 39 process. DON further stated staff had not been education after the medication error of R9 missing multiple days of missing her coumadin. DON stated her expectation for staff to follow physician orders and administer medication as directed. On 7/13/22, at 4:50 p.m. when interviewed consulting pharmacist (PHARM) stated it was serious concern and significant medication error for R9 not to receive her coumadin for 9 days who had a diagnosis of A-Fib. Consulting PHARM further stated this could have been a serious issue because R9 could have developed blood clots. Staff should contact provider regarding immediately when coumadin was not given, INR obtained, and obtain orders The facility's policy Transcribing Physician's Orders dated 3/13, directed staff to transcribe the order onto the MAR and into the electronic medical record and the nurse will sign the physician order sheet to signify the order had been completed. The policy further directed a second nurse will provide a second check on the order to ensure the order is correct. The facility policy directed the nurse to sign off the order to indicate the second checked was done.	F 760			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880			8/1/22

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F 880	Continued From page 40 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880			

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F 880	Continued From page 41 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff were using the proper personal protective equipment following the Centers for Disease Control (CDC) and the Minnesota Department of Health (MDH) guidelines to reduce the risk of transmission of COVID-19 when multiple staff were observed with improper eye protection, masking, and hand hygiene when working with residents who were positive for COVID-19 and resident who were not positive for COVID-19. Findings include: The facility grievance log indicated on 7/10/22, a	F 880	1. In continuing compliance with F880, Infection Prevention & Control, Woodlyn Heights Senior Living corrected the deficiency on 7/13/22 by immediately stocking 200-hall with adequate PPE supplies. PPE supplies stocked in storage space and made readily available to staff. Staff education started on proper hand hygiene and donning/doffing PPE. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 7/28/2022 or prior to their next scheduled shift on proper use of PPE and proper hand hygiene.		

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 07/13/2022
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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F 880	Continued From page 42 concern was reported a visitor was walking around the facility without a mask on in the hallways, and a staff person who passed medications was not wearing a mask. The CDC COVID Data Tracker indicated Dakota County community transmission rate was listed as "high" on 7/12/22 and 7/13/22. Review of the CDC guidance dated 2/2/22 indicated, Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic indicated staff working in health care facilities should follow standard and transmission based precautions, utilize source control, which included a well fitting facemask. HCP working in counties with substantial or high transmission should also wear eye protection such as goggles or a face shield covering the front and sides of the face during all resident encounters. The MDH COVID-19 PPE and Source Control Grids indicated HCP in congregate care settings including nursing homes, for any community transmission level if working with residents/clients with suspected or confirmed SARS-CoV-2 infection use PPE gown; gloves; eye protection; N95 or higher level respirator face mask. For community transmission levels high and substantial HCP use PPE face mask (source control) and eye protection. The facility's Staff COVID-19 List printed date of 7/12/22, indicated from 6/15/22, to 7/11/22, 11 staff had turned positive for COVID-19. The facility's Resident COVID-19 list printed date of 7/12/22, indicated from 6/29/22, to 7/11/22, 13	F 880	3. The DON and/or designee will audit donning/doffing of PPE and for proper hand hygiene on all shifts 4x a week for 1 week, then 2x a week for 1 week, then 1x a shift a week for 1 month, and then as needed to ensure compliance. The DON and/or designee will audit PPE supplies in designated storage space and isolation bins 3x week for 4 weeks, then 2x a week for 2 weeks, and then as needed to ensure continued compliance. 4. 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 880	Continued From page 43 residents had turned positive for COVID-19. Personal Protective Equipment observations and interviews on 7/12/22: - at 8:04 a.m. a sign is displayed on the front entrance doors to the facility, to direct staff and visitors to wear mask. No staff were located at the front entrance to observe, monitor, or direct visitors to sign in and ensure proper PPE is used. - at 8:05 a.m. upon entering the facility the assistant director of nursing (ADON) walked into the facility without a mask or goggles on. ADON walks into the building roughly 12 feet to a sign in for employees to check in. - at 8:37 a.m. registered nurse (RN)-C was observed in the 600-unit hallway next to room 604 doorway, not wearing any goggles. RN-C stated she must have left them in the nurse's station and acknowledge she should be wearing them. - at 8:39 a.m. licensed practical nurse (LPN)-D was observed with her face shield on her head, walking in the 600 Unit hallway, and grabbed vital signs monitor on a stand and walked 500 Unit and into a resident's room. LPN-D stated, " I forgot about putting my face shield down." - at 8:40 a.m. nursing assistant (NA)-A walked into room 603's room with no eye protection on. NA-A was holding washcloths in her hand. - at 8:45 a.m. RN-D was observed in the hallway of 400 unit not wearing eye protection. RN-D stated she had forgotten her goggles and need to go find some." - at 9:00 a.m. housekeeper (HSPK)-A was observed pushing a cleaning cart outside room 306. HSKP-A walked in resident's room 306 without goggles on and started to clean in the room while resident was present. HSKP-A stated she should be wearing her goggles. - at 9:12 a.m. NA-B was observed coming out of	F 880			

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F 880	Continued From page 44 a resident's room located on the dedicated COVID-19 200 unit not wearing eye protection. NA-B stated she was the only one working on the unit. - at 11:45 a.m. double doors of the COVID-19 200 unit, indicated with signs to wear glasses, mask and full PPE beyond this point on the other side of this door. - at 11:50 a.m. NA-B walked out of room 208 with no gloves on and did not perform hand hygiene. - at 11:57 a.m. NA-H pushed open the double door to the COVID-19, 200 unit and yells down the hallway "have you seen the aide?" NA-H did not have goggles on and her mask was pulled down under her chin. - at 12:00 p.m. laundry staff with no goggles on, pushed open the double doors to the COVID-19 unit and hung 8 clothing items on the door. - at 12:04 p.m. to 12:30 p.m. RN-A delivered meals to the residents on COVID-19 unit. RN-A was observed to don and doff PPE before and after she delivered meals to the residents. RN-A was observed not performing hand hygiene after removing PPE. - at 12:15 p.m. NA-H was observed to enter resident room 202 wearing a N-95 mask, gown, and gloves. At 12:30 p.m. NA-H was observed leaving room 202 caring a bag which contained a dirty gown and towels, removed her PPE, but NA-H did not sanitizer her hands. NA-H than proceeded to leave the COVID-19 unit. NA-H did not respond when asked about why she did not sanitizer her hands after she removed her gown and gloves, she wore when she provided care for resident in 202. - at 3:00 p.m. activity assistant (AA) was observed standing next to RN-D at a medication cart in the 400 unit. AA had her face mask down under her chin, no goggles, and was eating a bag	F 880			

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F 880	Continued From page 45 of baked chips. - at 3:18 p.m. NA-I was observed to enter resident in room 602, placed resident on wheeled shower chair, and proceeded to push the resident down the hallway. NA-I was not observed to wear eye protection which were observed resting on NA-I head. On 7/12/22, at 9:25 a.m. NA-B stated she had concerns regarding the outbreak of COVID-19 in the facility over the last two weeks. NA-B stated she is expected to go over to the 100 unit and help out with patient care if they are busy and at night only one aide is working both the 200 unit and 100 unit which means they come in and out of the unit to the other wing. NA-B stated she observed staff not wearing PPE as they should, and she was concerned COVID-19 would spread to the other units. NA-B further stated there is one bottle of hand sanitizer in the hallway and one bottle which hung in a residents room. On 7/13/22, at 9:30 a.m. the DON was interviewed and stated staff should always wear a mask in the building and eye protection when in resident care areas or around residents. DON further stated staff should wear appropriate PPE, before going into the COVID-19 unit. On 7/12/22, at 10:25 a.m. infection preventionist (IP)-A was interviewed and stated, currently the facility was in outbreak status and anyone entering the COVID-19 unit or a room of a resident who had COVID-19 positive should be wearing an N95 respirator, gown, gloves, eye protection. The IP-A further stated all staff should be performing hand hygiene and donning and doffing PPE before and leaving the resident's room. IP-A stated the facility did not have a	F 880			

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F 880	Continued From page 46 shortage or source control on PPE and staff are expected to wear PPE as directed. IP-A further stated it was not appropriate for staff to wear goggles on forehead while in resident care areas such as resident's room or hallways. On 7/13/22, at 3:00 p.m. IP-A stated she when she went down to the COVID-19 this morning the PPE bins did not have all the necessary PPE in the carts, no PPE outside the door of the COVID-19 unit, only two containers of hand sanitizer. IP-A stated she had not been down to the COVID-19 in a few days. IP-A further stated outside each room should be a precautions bin with the PPE required inside of them and hand sanitizer on the top, additionally the IP-A stated a red bag box to dispose of PPE should be inside each resident's room. IP-A further stated staff should not have their masked down and eating food in the hallways. IP-A stated during COVID-19 testing on 7/12/22, one resident had turned positive. Per facility policy titled, Cohorting residents and Dedicated Staffing, dated 6/28/22, indicated the facility will attempt to have dedicated staff for each cohort areas. Per facility policy titled, Personal Protective Equipment, dated 6/28/22, if the facility had one or more residents test positive for COVID-19, than all staff must wear a N95 and eye protection in a resident care area. The policy defined a resident care area to include resident rooms, nurse's station, activities, dining rooms, and hallways.	F 880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 25, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 2SVZ11

Dear Administrator:

The above facility was surveyed on July 12, 2022 through July 13, 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

July 25, 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:

Annette Winters, Rapid Response Unit Supervisor

Metro 1, Golden Rule 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: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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

Licensing and Certification Program

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00829	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/13/2022
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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
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/12/22-7/13/22, 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 07/28/22
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Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER

WOODLYN HEIGHTS HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**2060 UPPER 55TH STREET EAST
INVER GROVE HEIGHTS, MN 55077**

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H53203147C and H53203190C (MN00084714/MN00084842) with licensing order issued at 0920, 0930 H53203171C (MN00083949) with licensing order issued at 1375, 1665 H53203170C (MN00084221) with licensing order issued at 1375 H53202947C (MN00084551) with licensing order issued at 1545 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	2 000		

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2 000	Continued From page 2 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 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		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely assistance with incontinence cares for 3 of 3 residents (R1, R2, R5) who required total assistance with checking and changing of incontinence products.	2 920	Corrected	8/1/22

Minnesota Department of Health

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2 920	Continued From page 3 Findings include: The facility Grievance logs undated, indicated from 6/24/22, to 7/10/22, ten grievances were filed with the facility. Grievances: - On 6/6/22, indicated a resident had not been checked for three hours. - On 6/28/22, indicated a resident had concerns because he put his call light on to receive pain medications, and 45 minutes later before someone to come. Staff will walk by resident's room with call light on. - On 7/5/22, indicated a resident had been lying in bed wet and appeared no one cleaned at night. Staff complain about being short staff and no one cleaned the bedding until 11:30 a.m. - On 7/6/22, indicated concerns regarding call light on and no one comes, then comes with attitude. No two-hour checks or water and room is messy. - On 7/10/22, indicated concerns regarding call light on since 1:22 p.m., aide stated she would come back but went on break, and finally assisted at 2:45 p.m. R1's care plan dated 6/20/22, indicated R1 had a ADL self-care performance deficit related to pneumonia, and esophageal obstruction and directed staff to assist with dressing, eating, oral care, and toilet use. R1's care plan further indicated R1 had incontinence of bowel and bladder and directed staff to provide perineal care after incontinent episode, use absorbent pads, and encouraging toileting. R1's admission Minimum Data Set (MDS) dated 6/26/22, indicated R1 was cognitively intact, required extensive assistance for toilet, personal hygiene, and dressing. R1's MDS further	2 920		

Minnesota Department of Health

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2 920	Continued From page 4 indicated R2 had diagnoses of pneumonia, malignant neoplasm (cancer) of pharynx, and COVID-19. R1's activities of daily living Care Area Assessment (CAA) and urinary CAA dated 6/26/22 were triggered and addressed on care plan. R1's call light log dated 7/13/22, indicated R1 call light was on: - for 52 minutes on 7/5/22, at 1:25 p.m. - for 75 minutes on 7/6/22, at 7:21 p.m. - for 46 minutes on 7/7/22, at 5:39 a.m. - for 52 minutes on 7/7/22, at 7:20 a.m. - for 75 minutes on 7/8/22, at 8:13 a.m. - for 79 minutes on 7/8/22, at 7:17 p.m. - for 96 minutes on 7/9/22, at 8:05 a.m. - for 29 minutes on 7/10/22, at 4:53 a.m. - for 82 minutes on 7/10/22, at 10:14 a.m. - for 15 minutes on 7/12/22, at 10:41 a.m. - for 29 minutes on 7/12/22, at 9:13 p.m. On 7/12/22, at 8:55 a.m. R1 was observed lying in his bed with his head of bed up at a 75-degree angle with his incontinent brief unsecured on the right side, and dressed in a hospital gown, eating hot cereal. R1 stated "can you turn the light on in my room while I eat," staff just come in and out so quickly. R1 stated he does not like to use the call light because he had to wait so long it does not help if he put it on. On 7/12/22, at 1:30 p.m. during observation and interview R1 was observed lying in bed in a soiled with white colored food stain gown, incontinent brief on and was soiled with urine. R1 stated "can you asked them to help me, I had been waiting for more than 25 minutes after the aide told me she would come back." R1 further stated	2 920		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER

WOODLYN HEIGHTS HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**2060 UPPER 55TH STREET EAST
INVER GROVE HEIGHTS, MN 55077**

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2 920	Continued From page 5 it is uncomfortable. R1's Kardex dated 7/13/22, directed staff to provide perineal care after incontinence care, oral cares, dressing, and bed mobility. R1's Kardex further directed staff apply barrier cream to exposed areas, and to use absorbent briefs that wick and hold moisture. On 7/13/22, at 11:00 a.m. family member (FM)-B stated she had concerns for R1 overall care and how staff were managing cares which included incontinent cares, dressing, and bathing. FM-B stated R1 would put on his call light, and it would be on for over an hour. R1 should not have to wait that long if he needed something especially because he is dependent on staff for his cares. R2's admission Minimum Data Set (MDS) dated 5/31/22, indicated R2 was cognitively intact, required extensive assistance with two staff for toilet use and personal hygiene. R2's MDS further indicated R2 had diagnoses of dissection of thoracic aorta (serious condition in which a tear occurs in the inner layer of the body's main artery (aorta), diabetes, heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and urinary retention (condition in which you cannot empty all the urine from your bladder). R2's activities of daily living Care Area Assessment (CAA) and urinary CAA dated 5/31/22 were triggered and addressed on care plan. R2's care plan dated 5/25/22, indicated R2 had a limited physical mobility related to fall risk and directed staff to assist with turn and repositioning, and transfers. R2's care plan further indicated R2	2 920		

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2 920	Continued From page 6 had a potential/actual impairment to skin integrity and directed staff to keep skin clean and dry . R2's admission note dated 5/25/22, at 11:14 p.m. indicated R2 was admitted around 4:00 p.m., was incontinent of bowels and had a catheter in place. R2's admission note further indicated R2 required the use of a mechanical lift and had four small open pressure ulcers on the coccyx. R2's Fall Risk summary dated 5/26/22, indicated R2 was a high risk for falls. R2's skilled charting progress note (PN) dated 5/27/22, R2's current functional status was R2 did not bear weight, had an unsteady gate and weakness. R2's PN further indicated R2 had late loss ADL concerns and required assistance with toileting, bed mobility, and transfers. R2's nurse PN dated 5/31/22, indicated FM-A complained of R2 being weak, lethargic, and running a temperature. R2's social worker PN dated 5/31/22, at 9:29 p.m. indicated FM-A was unhappy with the facility regarding how R2 had not been allowed to use the toilet. During interview on 7/13/22, at 10:52 a.m. R2's family member (FM)-A stated she was very unhappy with the care her mom was receiving at the facility. FM-A further stated the carpet in the hallways was dirty and smelled of old urine. FM-A stated she was concerned her mm had to sit in an incontinent brief soiled and when FM-A put on call light no one would come for more than 20 minutes. FM-A stated her R2 was supposed to be toileted every two hours and that never happened, staff told R2 they would clean her up	2 920		

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2 920	Continued From page 7 and left the room. On another occasion, FM-A stated when she had visited R2, R2 had been sitting in feces soiled incontinent brief for more than three hours before staff would change her. FM-A stated she had reported her concerns to the social worker. FM-A stated R2 was admitted to the hospital after she complained regarding a change in condition and R2 developed a urinary tract infection and sepsis. FM-A further stated if the facility staff would have not made R2 wait so long in feces soiled brief R2 would not have gotten an infection. FM-A stated she observed staff dropping the catheter tubing on dirty stained floor and not cleaning afterwards. During interview with social worker (SW) on 7/13/22, at 2:32 p.m. SW stated FM-A had reported concerns regarding R2 care while in the facility but was unable to remember exactly what the concerns were about. R5's annual Minimum Data Set (MDS) dated 2/3/22, indicated R5 was cognitively intact, required extensive assistance of two staff to assist with toilet use and personal hygiene. R5's MDS further indicated R5 was always incontinent of bowel and bladder. R5's MDS indicated R5 had diagnoses of quadriplegia (paralysis from the neck down, including the trunk, legs and arms), urinary tract infection, pressure ulcer stage four in the sacral region (bottom of the spine pressure injury is very deep, reaching into muscle and bone and causing extensive damage), and sepsis (life-threatening complication of an infection). R5's activities of daily living Care Area Assessment (CAA) and urinary CAA dated 2/3/22, were triggered and addressed on care plan.	2 920		

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2 920	Continued From page 8 R5's care plan dated 2/4/21, indicated R5 had an ADL self-care deficit related to wrist fracture, multiple sclerosis, weakness, and impaired cognition. R5's care plan indicated R5 required two staff for total assistance for to use toilet. R5's care plan directed staff to check and change every two to three hours and as needed. R5's care plan further indicated R5 was incontinence of bowel and bladder related to multiple sclerosis and functional loss and directed staff to use barrier cream to areas exposed to moisture, encourage toileting, and observe skin during cares. R5's hospital Discharge Summary dated 7/8/22, at 3:31 p.m. indicated R5 had a Complicated UTI (urinary tract infection) with bacteria growth showing E. coli (type of bacteria commonly found in the gastrointestinal (GI) tract) and COVID-19. R5's Discharge summary further indicated R5 was placed on cephalexin (antibiotic) for severe sepsis. R5's nurse PN dated 7/3/22, at 6:24 p.m. indicated R5 was sent to the hospital at 12:30 p.m. for shortness of breath, and increased heart rate at 133. R5's PN further indicated R5 had positive COVID-19 rapid test. R5's nurse PN dated 7/8/22, at 6:34 p.m. indicated R5 was admitted to the facility after hospitalization related to urosepsis and was on antibiotic therapy. R5's Comprehensive Skin and Positioning PN dated 7/12/22, at 1:09 p.m. indicated R5 current urinary tract infection. R5's nurse progress note (PN) dated 7/12/22, at 10:23 p.m. indicated R5 continued on antibiotics	2 920		

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2 920	Continued From page 9 for urosepsis. R5's Kardex dated 7/13/22, indicated R5 required two staff to assist with toileting and directed staff to check and change every two to three hours and as needed. R5's Kardex further directed staff to use barrier cream to areas exposed to moisture. R5's call light log dated 7/13/22, indicated R5 call light was on: - for 43 minutes on 7/11/22, at 4:01 a.m. - for 17 minutes on 7/12/22, at 4:33 a.m. - for 26 minutes on 7/12/22, at 9:29 a.m. - for 19 minutes on 7/12/22, at 12:18 p.m. - for 40 minutes on 7/12/22, at 2:47 p.m. - for 50 minutes on 7/12/22, at 5:30 p.m. - for 41 minutes on 7/13/22, at 8:02 a.m. During observation and interview on 7/12/22 at 8:41 a.m. R5 had her call light on. R5 stated it had been on for over 30 minutes, and she needed to have her incontinent brief change. R5 further stated she had to wait almost every day. R5 stated she becomes uncomfortable lying in a soiled brief and she was concerned because she had a recent UTI. R5's call light was observed to be on for 35 minutes. During interview on 7/12/22, at 9:25 a.m. nursing assistant (NA)-B stated she was the only one working in the COVID-19 200 unit with 11 residents who all need a lot of assistance. NA-B stated she can only go so fast with everything she needed to do. When interviewed on 7/13/22, at 3:00 p.m. director of nursing (DON) stated, residents call lights should be answered in a timely fashion and could be answered by anyone. The DON stated	2 920		

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2 920	Continued From page 10 when the resident puts on a call light it indicates the resident is in need of something and more than 10 minutes is too long. The DON further stated some resident had voiced concerns regarding long call lights. A facility policy was requested for call light assistance, and none were received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 920		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced	2 930		8/1/22

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2 930	Continued From page 11 by: Based on observation, interview and document review, the facility failed to ensure G-tube placement were checked prior to water flushes and G-tube supplies were replaced every 24 hours for 1 of 1 (R1) reviewed with a G-tube. Findings include: R1's care plan dated 6/20/22, indicated R1 had tube feeding related to dysphagia and history of throat cancer. R1's care plan directed staff to administer tube feeding and water flushes as ordered. R1's care plan lacked indication staff should check for placement prior to administration tube feeding and water flushes. R1's nutritional assessment dated 6/21/22, indicated R1 had no swallowing disorders. R1's nutritional assessment further indicated R1 had G-tube. R1's physician initial intake progress note (PN) dated 6/23/22, indicated R1 had a hospitalization from 6/15/22, to 6/20/22, for pneumonia. R1's PN further indicated R1 had a video swallow with speech therapist on 6/16/22, which indicated frank aspiration with delayed cough reflux was found with thin consistency swallow. On 6/15/22, R1's chest X-ray while in the hospital indicated R1 had developed atypical pneumonia and was diagnosed with aspiration pneumonia. R1's admission Minimum Data Set (MDS) dated 6/26/22, indicated diagnoses that included esophageal obstruction (abnormal tightening or narrowing of the esophagus), esophagitis (Inflammation that damages the tube running from the throat to the stomach (esophagus), malignant neoplasm of pharynx (cancer of	2 930	Corrected	

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2 930	Continued From page 12 throat), pneumonia (infection in lungs), and adult failure to thrive. The MDS indicated R1 received tube feedings. R1's care area assessment (CAA) dated 6/26/22, indicated R1 received more than 51 percent of total calories by tube feeding and received more than 501 ml of fluid by mouth daily. R1's treatment administration record (TAR) dated 7/1/22, directed staff to clean tube feeding pump and pole every night shift and change and date bag, tubing, syringe, and piston every night. R1's TAR lacked direction for staff to check placement prior to administration of tube feeding and water flushes. R1's nurse practitioner (NP) PN dated 7/3/22, indicated R1 physical exam demonstrated coarse crackles at lung bases bilaterally. R1's nurse progress note (PN) dated 7/5/22, indicated R1 tube feeding was beeping on and off. R1's nurse PN dated 7/10/22, at 9:56 p.m. indicated R1's G-tube had blown. PN further indicated the physician stated it needed to be changed and would be best to be done on Monday. R1's nurse PN dated 7/11/22, 9:17 a.m. indicated R1 had returned from the hospital with new G-tube placement. R1's speech therapy (SP) PN dated 7/13/22, indicated R1 had precautions of aspiration risk, was on a pureed diet, and R1 had a G-tube. R1's physician orders dated 7/13/22, indicated R1	2 930		

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2 930	Continued From page 13 had orders for: - Elevate the head of bed at least 30-45 degrees while tube feeding is running every shift. - Flush G-tube (type of feeding tube) with 150 ml of water every four hours for G-tube flushing. - Isosource 1.5 cal 60 ml/hour. Stop feedings at 5:00 a.m. for nutritional support. - Tube feeding cleaning: clean tube feeding pump and pole every night. - Tube feeding equipment change: Change and date bag, tubing, syringe, and piston every night shift. On 7/12/22, at 8:40 a.m. during observation in R1's room was a graduated cylinder and syringe dated 6/22/22. Registered nurse (RN)-A stated she used the graduated cylinder and syringe to give R1 his water flushes this morning. RN-A acknowledged the date of 6/22/22, and stated it should be changed once a day. RN -A did not respond when asked why the date of 6/22/22, was on the cylinder or if she had gotten a new one during her shift. On 7/13/22, at 12:00 p.m. R1 was observed lying on his bed. RN- B indicated R1 was due for water flushes per the physician's order. At 12:05 p.m. RN-B retrieved the graduated cylinder and syringe and filled the graduated cylinder up with 175 milliliters (ml) of water. RN-B attached the syringe to the port of the G-tube and proceeded to pour the water in to the syringe allowing the water to instill by gravity without checking for placement. RN-B repeated the process three times. R1 garbage can had a graduated cylinder dated 6/22/22, with a syringe. On 7/13/22 at 12:10 p.m. RN-B acknowledged he had not checked the G-tube placement prior to administering the water flushes. RN-B stated R1	2 930		

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2 930	Continued From page 14 did not have an order to check placement before giving water flushes. RN-B further stated placement should be checked prior to medication, water flushes, or administering tube feeding. RN-B stated he noticed the graduate cylinder and syringe R1 had in his room which was used for water flushes was dated 6/22/22, and he threw it away because it should be changed every 24 hours. RN -B further stated reusing the graduate cylinder and syringe for longer than 24 hours could harbor bacteria and increase the risk for infection. On 7/13/22, at 11:00 a.m. family member (FM)-B stated she had concerns for R1 and how staff were managing cares for R1 G-tube. FM-B stated R1 G-tube was reported to her as "blown" and was sent to the hospital for a replacement. On 7/13/22, at 2:56 p.m. nurse practitioner (NP)-A stated nursing staff should ensure that the tube is located in the stomach. NP-A stated R1 had COVID-19 and had been coughing which could cause the G-tube to move from the correct placement. On 7/13/22, at 2:07 p.m. the director of nursing (DON) stated she expected tube placement to be checked prior to administering medications, water flushes, and tube feedings. DON further stated the graduate cylinder and syringe should be replaced every 24 hours and is indicated on the orders. The facility policy Enteral Tube revision date 3/12/14, directed staff to check placement by drawing up 10-15 cubic centimeter cc (of air in a 60-cc piston syringe, listen with stethoscope and inject the 10-15 cc of air into the port G-tube feeding port, and listen for a gurgle noise. The	2 930		

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2 930	Continued From page 15 policy further directed staff to than pull back on syringe and exam for stomach contents. The facility policy directed staff to check for placement prior to administering fluids via G-tube. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 930		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff were using the proper personal protective equipment following the Centers for Disease Control (CDC) and the Minnesota Department of Health (MDH) guidelines to reduce the risk of transmission of COVID-19 when multiple staff were observed with improper eye protection, masking, and hand hygiene when working with residents who were positive for COVID-19 and resident who were not positive for COVID-19. Findings include:	21375	Corrected	8/1/22

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INVER GROVE HEIGHTS, MN 55077**

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21375	Continued From page 16 The facility grievance log indicated on 7/10/22, a concern was reported a visitor was walking around the facility without a mask on in the hallways, and a staff person who passed medications was not wearing a mask. The CDC COVID Data Tracker indicated Dakota County community transmission rate was listed as "high" on 7/12/22 and 7/13/22. Review of the CDC guidance dated 2/2/22 indicated, Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic indicated staff working in health care facilities should follow standard and transmission based precautions, utilize source control, which included a well fitting facemask. HCP working in counties with substantial or high transmission should also wear eye protection such as goggles or a face shield covering the front and sides of the face during all resident encounters. The MDH COVID-19 PPE and Source Control Grids dated 4/7/22 indicated HCP in congregate care settings including nursing homes, for any community transmission level if working with residents/clients with suspected or confirmed SARS-CoV-2 infection use PPE gown; gloves; eye protection; N95 or higher level respirator face mask. For community transmission levels high and substantial HCP use PPE face mask (source control) and eye protection. The facility's Staff COVID-19 List printed date of 7/12/22, indicated from 6/15/22, to 7/11/22, 11 staff had turned positive for COVID-19. The facility's Resident COVID-19 list printed date	21375		

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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 07/13/2022
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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21375	Continued From page 17 of 7/12/22, indicated from 6/29/22, to 7/11/22, 13 residents had turned positive for COVID-19. Personal Protective Equipment observations and interviews on 7/12/22: - at 8:04 a.m. a sign is displayed on the front entrance doors to the facility, to direct staff and visitors to wear mask. No staff were located at the front entrance to observe, monitor, or direct visitors to sign in and ensure proper PPE is used. - at 8:05 a.m. upon entering the facility the assistant director of nursing (ADON) walked into the facility without a mask or goggles on. ADON walks into the building roughly 12 feet to a sign in for employees to check in. - at 8:37 a.m. registered nurse (RN)-C was observed in the 600-unit hallway next to room 604 doorway, not wearing any goggles. RN-C stated she must have left them in the nurse's station and acknowledge she should be wearing them. - at 8:39 a.m. licensed practical nurse (LPN)-D was observed with her face shield on her head, walking in the 600 Unit hallway, and grabbed vital signs monitor on a stand and walked 500 Unit and into a resident's room. LPN-D stated, " I forgot about putting my face shield down." - at 8:40 a.m. nursing assistant (NA)-A walked into room 603's room with no eye protection on. NA-A was holding washcloths in her hand. - at 8:45 a.m. RN-D was observed in the hallway of 400 unit not wearing eye protection. RN-D stated she had forgotten her goggles and need to go find some." - at 9:00 a.m. housekeeper (HSKP)-A was observed pushing a cleaning cart outside room 306. HSKP-A walked in resident's room 306 without goggles on and started to clean in the room while resident was present. HSKP-A stated she should be wearing her goggles. - at 9:12 a.m. NA-B was observed coming out of	21375		

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21375	Continued From page 18 a resident's room located on the dedicated COVID-19 200 unit not wearing eye protection. NA-B stated she was the only one working on the unit. - at 11:45 a.m. double doors of the COVID-19 200 unit, indicated with signs to wear glasses, mask and full PPE beyond this point on the other side of this door. - at 11:50 a.m. NA-B walked out of room 208 with no gloves on and did not perform hand hygiene. - at 11:57 a.m. NA-H pushed open the double door to the COVID-19, 200 unit and yells down the hallway "have you seen the aide?" NA-H did not have goggles on and her mask was pulled down under her chin. - at 12:00 p.m. laundry staff with no goggles on, pushed open the double doors to the COVID-19 unit and hung 8 clothing items on the door. - at 12:04 p.m. to 12:30 p.m. RN-A delivered meals to the residents on COVID-19 unit. RN-A was observed to don and doff PPE before and after she delivered meals to the residents. RN-A was observed not performing hand hygiene after removing PPE. - at 12:15 p.m. NA-H was observed to enter resident room 202 wearing a N-95 mask, gown, and gloves. At 12:30 p.m. NA-H was observed leaving room 202 carrying a bag which contained a dirty gown and towels, removed her PPE, but NA-H did not sanitizer her hands. NA-H then proceeded to leave the COVID-19 unit. NA-H did not respond when asked about why she did not sanitizer her hands after she removed her gown and gloves, she wore when she provided care for resident in 202. - at 3:00 p.m. activity assistant (AA) was observed standing next to RN-D at a medication cart in the 400 unit. AA had her face mask down under her chin, no goggles, and was eating a bag of baked chips.	21375		

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21375	Continued From page 19 - at 3:18 p.m. NA-I was observed to enter resident in room 602, placed resident on wheeled shower chair, and proceeded to push the resident down the hallway. NA-I was not observed to wear eye protection which were observed resting on NA-I head. On 7/12/22, at 9:25 a.m. NA-B stated she had concerns regarding the outbreak of COVID-19 in the facility over the last two weeks. NA-B stated she is expected to go over to the 100 unit and help out with patient care if they are busy and at night only one aide is working both the 200 unit and 100 unit which means they come in and out of the unit to the other wing. NA-B stated she observed staff not wearing PPE as they should, and she was concerned COVID-19 would spread to the other units. NA-B further stated there is one bottle of hand sanitizer in the hallway and one bottle which hung in a residents room. On 7/13/22, at 9:30 a.m. the DON was interviewed and stated staff should always wear a mask in the building and eye protection when in resident care areas or around residents. DON further stated staff should wear appropriate PPE, before going into the COVID-19 unit. On 7/12/22, at 10:25 a.m. infection preventionist (IP)-A was interviewed and stated, currently the facility was in outbreak status and anyone entering the COVID-19 unit or a room of a resident who had COVID-19 positive should be wearing an N95 respirator, gown, gloves, eye protection. The IP-A further stated all staff should be performing hand hygiene and donning and doffing PPE before and leaving the resident's room. IP-A stated the facility did not have a shortage or source control on PPE and staff are expected to wear PPE as directed. IP-A further	21375		

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21375	Continued From page 20 stated it was not appropriate for staff to wear goggles on forehead while in resident care areas such as resident's room or hallways. On 7/13/22, at 3:00 p.m. IP-A stated she when she went down to the COVID-19 this morning the PPE bins did not have all the necessary PPE in the carts, no PPE outside the door of the COVID-19 unit, only two containers of hand sanitizer. IP-A stated she had not been down to the COVID-19 in a few days. IP-A further stated outside each room should be a precautions bin with the PPE required inside of them and hand sanitizer on the top, additionally the IP-A stated a red bag box to dispose of PPE should be inside each resident's room. IP-A further stated staff should not have their masked down and eating food in the hallways. IP-A stated during COVID-19 testing on 7/12/22, one resident had turned positive. Per facility policy titled, Cohorting residents and Dedicated Staffing, dated 6/28/22, indicated the facility will attempt to have dedicated staff for each cohort areas. Per facility policy titled, Personal Protective Equipment, dated 6/28/22, if the facility had one or more residents test positive for COVID-19, than all staff must wear a N95 and eye protection in a resident care area. The policy defined a resident care area to include resident rooms, nurse's station, activities, dining rooms, and hallways. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to	21375		

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21375	Continued From page 21 ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21375		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation	21545		8/1/22

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21545	Continued From page 22 must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a system for accurate transcription of physician and medication orders for 1 of 1 residents (R4) with a history of congestive heart failure (CHF) who had medication omitted for 26 days, was subsequently hospitalized, and had a decline in activities of daily living (ADLs) as a result of the missed administration of medication resulting in harm. The facility further failed to ensure an International Normalized Ratio (INR a standard lab test used when taking blood-thinning medications) result was sent to the provider and obtained per physician order for coumadin. The facility failed to administer coumadin (a blood-thinning medication) per the INR level for nine (9) days for 1 of 1 (R9) residents reviewed for coumadin use. Findings include: R4's care plan dated 11/12/21, indicated R4 had an altered cardiovascular status related to cerebrovascular accident (CVA) loss of blood flow to part of the brain, which damages brain tissue),	21545	Corrected	

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21545	Continued From page 23 congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and hypertension (HTN) high blood pressure. R4's care plan directed staff to observe, document, and report to medical practitioner as needed any signs of symptoms of altered cardiac output or pacemaker malfunction such as dizziness, syncope, difficulty breathing, pulse rate lower than programmed rate, or lower than base line blood pressure. R4's significant change status Minimum Data Set (MDS) dated 5/2/22, indicated R4 had severe cognitive impairment and had diagnoses of stroke, heart failure, hypertension, diabetes, and COPD. R4's medication administration record (MAR) dated 5/22, indicated R4 was given one dose of furosemide 40 mg for diastolic heart failure on 5/27/22. R4's MAR lacked indication R4 was given from 5/28/22, to 5/31/22, which was a total of 4 days of furosemide was missed. R4's hospital discharge orders dated 5/27/22, indicated R4 had a medication regimen change with furosemide 40 mg tablet every morning was added for HF chronicity. The hospital discharge orders lacked indicated a second check was completed by another nurse because of the lack of signature. R4's primary nurse practitioner (NP) admission to facility note dated 5/31/22, indicated R4's weight on 5/27/22, at 7:00 a.m. R4 weighed 121 lbs 9.6 oz. R4's was observed to be seated in her chair wearing four (4) liters of oxygen. Weight was 5/31/22, at the facility was 131 pounds.	21545		

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21545	Continued From page 24 R4's dietary PN dated 6/1/22. at 11:37 p.m. indicated R4's current weight was 131.5 pounds. R4's NP's progress note dated 6/13/22, weight 128.4 lbs. Oxygen saturation (O2 sat) were 94 percent on room air. PN's indicated not on Lasix, weight is up, and had new edema. PN further indicated plan to add Lasix 10 mg daily. R4's PN dated 6/17/22, at 4:42 p.m. indicated to monitor R4 for signs and symptoms of fluid overload due to recent weight gain. R4's MAR dated 6/22, indicated R4 had no doses of furosemide were given to R4 from 6/1/22 to 6/22/22, which was a total of 22 days of furosemide was missed. R4' weight summary indicated R4 weights: - On 6/1/22, R4's weight was 131 lbs. - On 6/3/22, R4's weight was 125 lbs. - On 6/4/22, R4's weight was 125 lbs. - On 6/9/22, R4's weight was 128.4 lbs. - On 6/14/22, R4's weight was 130.6 lbs. - On 6/16/22, R4's weight was 135 lbs. - On 6/17/22, R4's weight was 142 lbs. - On 6/18/22, R4's weight was 143 lbs. - On 6/19/22, at 10:24 a.m. R4's weight was 143.2 lbs. - On 6/19/22, at 12:27 p.m. R4's weight was 144 lbs. - On 6/20/22, p.m. R4 weight 142.6 lbs. R4's weight log lacked indication staff weighed R4 daily. R4's PN dated 6/22/22, at 11:02 p.m. indicated R4 was found to have shortness of breath, wheezing was audible on inhalation and	21545		

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21545	Continued From page 25 expiration. Crackles heard in left lower mid lung with wheezes bilaterally in lungs. Orders received to send R4 to emergency room. R4's hospital Admission History and Physical dated 6/22/22, at 3:39 p.m. indicated R4 was sent to the emergency room for evaluation of shortness of breath from the facility. R4 was admitted to the hospital for treatment of her CHF and underwent a right-side thoracentesis. The report indicated R4 was discharged from a previous hospitalization to the facility on 5/27/22, but R4 reported she had progressively got shorter of breath and wheezing. R4's H&P indicated R4 abdomen was bloated and R4 reported she felt like she had gained quite a bit of weight, and significant lower extremity edema. R4 further reported to the hospital staff, when she was talking to family member (FM) -E, FM-E noted she sounded "terrible". Her weight was documented at 144 pounds (lb) 6.4 ounces (oz). R4 echocardiogram demonstrated pleural effusion. R4's primary diagnosis for her hospital admission was acute on chronic diastolic heart failure and per pharmacy records R4 had not been receiving the furosemide she was ordered on 5/27/22, from her last hospitalization. R4 received 40 milligrams (mg) intravenous furosemide in the emergency room and 40 mgs every eight (8) hours and a thoracentesis. R4's hospital discharge summary 7/1/22, indicated R4 was hospitalized from 6/22/22 to 7/1/22, for the diagnoses of acute on chronic diastolic heart failure (acute heart failure is a sudden, life-threatening condition in which the heart is unable to do its job.) R4's admission nurse PN dated 7/1/22, indicated R4's weight was 122.4 lbs was 124 lbs.	21545		

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21545	Continued From page 26 R4's Kardex dated 7/13/22, directed staff to obtain weight. On 7/12/22, at 11:14 a.m. during interview family member (FM)-E, stated she had concerns regarding her mom's care and how the facility missed a physician's order for so long to cause R4 to be admitted to the hospital for something avoidable. On 7/12/22, at 1:17 p.m. registered nurse (RN)-C stated orders should be placed into the electronic medical record first, then the paper orders are placed on the shelf in the nurse's station for the next shift to complete a second check. The second check nurse would put their initials on the paper orders once reviewed. On 7/12/22, at 1:30 p.m. during interview with licensed practical nurse (LPN)-D stated the order processed is "messed up" and had changed recently. She further stated orders are sometimes placed anywhere in the chart rather than in the order section of the hard chart. LPN-D stated she is unsure of what the process for orders was and had seen orders get missed recently with another error of a resident not receiving medication. On 7/12/22, at 2:57 p.m. RN - B stated when we receive an order we enter into the electronic health record, put the order into the hard chart, and put out the red flag, set on the shelf for the next shift to review and sign off on. RN-B stated the orders should be put in the orders tab in the hard chart. On 7/12/22, at 5:30 p.m. nurse practitioner (NP) - A stated R4's recent hospitalization was directly correlated to not receiving her Lasix 40 mg as	21545		

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21545	Continued From page 27 ordered from her previous hospital discharge. NP-a further stated R4 could have avoided having a hospitalization and thoracentesis if Lasix was given as ordered, follow up with assessment such as monitoring for edema and weights. NP-A stated R4 was medically complex and a brittle diabetic who needed to be managed carefully. NP-A further stated she is unsure of what happened other than a transcription error. On 7/13/22, at 12:17 p.m. when interviewed the director of nursing (DON) stated the admitting nurse transcribed the order wrong into the electronic health record. She further stated there was no second check completed to verify the order was entered correctly. DON further stated on 5/24/22, the process for entering orders changed from the health unit coordinator starting the process of entering the order into the electronic health record, reviewed by the nurse to sign off on. The facility changed the process to using a two step nurse review to sign off. The DON stated the staff were educated by the interim DON while she was out on leave and verified not all staff including agency were educated on the entering order process. DON further stated her expectation for staff would be to follow provider order and policy/procedure. On 7/13/22, at 4:50 p.m. when interviewed consulting pharmacist stated it was serious concern and significant medication error for R4 not to receive her furosemide 40 mg for her congestive heart failure for 22 days causing her to be admitted into the hospital. Consulting pharmacist stated he was not notified of the medication error but should be reviewed at the QAPI meeting. On 7/13/22, at 4:50 p.m. when interviewed consulting pharmacist stated it was serious concern and significant medication error	21545		

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INVER GROVE HEIGHTS, MN 55077**

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21545	Continued From page 28 for R4 not to received her furosemide 40 mg for her congestive heart failure for 22 days causing her to be admitted into the hospital. Consulting pharmacist stated he was not notified of the medication error but should be reviewed at the QAPI meeting. The facility policy on standing orders dated 1/17/22, directed staff for heart failure management to" - Obtain daily weights. - For weight gain of greater than two and half pounds in 48 hours, or five pounds above admission weight. - Assess lung sounds, peripheral edema, and respiratory effort daily. R9's hospital Transfer Orders dated 4/22/22, indicated R9 was to take Warfarin 3 mg daily for atrial fibrillation (A-Fib). R9's care plan dated 4/22/22, indicated R9 had an alteration in hematological status and directed staff to administer medication as ordered, observe for side effects, and report any complications. R9's care plan further directed staff to obtain lab and diagnostic work as order and report results to the provider as indicated. R9's significant change in status MDS dated 5/11/22, indicated R9 was cognitively intact and had diagnoses which included fracture of lumbar vertebra and atrial fibrillation. R9's MDS further indicated R9 required extensive assistance from two staff for activities of daily (ADL's) which included bed mobility and transfers. R9's MDS indicated R9 had impairment on one side of her upper extremity and both lower extremities. R9's Order Summary dated 7/13/22, lacked	21545		

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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		
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21545	Continued From page 29 indication R9 was on coumadin (medication is used to treat or prevent blood clots) and anticoagulant (blood thinner). R9's medication administration record (MAR) dated 7/22, indicated R9 had an order for: - Warfarin sodium tablet three (3) mg one time a day at 6:00 p.m. on 7/9/22, through 7/11/22. - On 7/12/22, Coumadin use: Resident is on coumadin and directed staff if no active coumadin orders to follow up with provider and laboratory for orders, every shift. R9's MAR dated 7/22, lacked indication R9 received coumadin from 7/1/22 to 7/9/22. Medication Error Incident report dated 7/11/22, indicated on 7/9/22, it was discovered nursing staff had not processed the INR lab draw that was done on 6/30/22, and staff did not contact the provider to get new coumadin orders for the resident. R9's incident report indicated interdisciplinary team (IDT) reviewed the medication error. The root cause for R9's medication error was related to failure to complete INR/coumadin process. A nurse reported she was not aware R9 received coumadin due to no order being on R9's MAR. A coumadin use alert was added to the resident MAR to alert R9 took coumadin. R9's medication error incident report lacked indication education was completed to staff after this incident occurred. R9's treatment administration record (MAR) dated 7/22, directed staff to check an INR on 7/13/22 and call provider with results. R9's Anti-Coagulant Flow Sheet undated, indicated R9 had A-Fib, and on 6/30/22, R3 had a	21545		

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21545	Continued From page 30 current dose of coumadin 3 mg daily with an INR of 4.45 with new dose to be coumadin 3 mg daily until 7/13/22. R9's Flow Sheet further directed staff to recheck INR on 7/13/22. On 7/13/22 R9's INR was 1.34. On 7/13/22, at 2:00 p.m. the DON stated another medication error occurred for R9 and R9 did not receive coumadin for many days because nursing staff did not complete the medication order process. DON further stated staff had not been education after the medication error of R9 missing multiple days of missing her coumadin. DON stated her expectation for staff to follow physician orders and administer medication as directed. On 7/13/22, at 4:50 p.m. when interviewed consulting pharmacist (PHARM) stated it was serious concern and significant medication error for R9 not to receive her coumadin for 9 days who had a diagnosis of A-Fib. Consulting PHARM further stated this could have been a serious issue because R9 could have developed blood clots. Staff should contact provider regarding immediately when coumadin was not given, INR obtained, and obtain orders The facility's policy Transcribing Physician's Orders dated 3/13, directed staff to transcribe the order onto the MAR and into the electronic medical record and the nurse will sign the physician order sheet to signify the order had been completed. The policy further directed a second nurse will provide a second check on the order to ensure the order is correct. The facility policy directed the nurse to sign off the order to indicate the second checked was done. The facility's Medication Error Incident Report	21545		

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21545	Continued From page 31 dated 7/12/22, indicated three residents had medication errors from 6/14/22, to 7/11/22. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21545		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a safe, homelike, and comfortable environment for 12 of 12 residents reviewed for environmental concerns. In addition, the facility failed to ensure the 200-unit hallway areas and lounge were kept clean and free of garbage and odors, good lighting, and comfortable temperatures. This deficient practice had the potential to affect all residents who utilized these areas. Findings include: The facility grievance reports dated: - 6/27/22, reported concerns of room cleanliness. - 7/6/22, reported concerns of a messy room.	21665	Corrected	8/1/22

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21665	Continued From page 32 On 7/12/22 at 9:05 a.m. during observation when entering the closed double doors of the 200-unit an overwhelming malodorous smell of garbage and feces emanated the air. The hallway and lounge area were observed. Near room 205 was a large red bag open sitting on the floor filled with used disposable food serving containers with uneaten food, open cartons of milk, and cups. Near the room labeled "Hopper" was a clear plastic bag with an incontinent brief soiled with feces and used cleansing wipes sitting on the floor in front of the door. Each of the occupied residents' room had a 36 inch by 25-inch medical waste disposal cardboard box container with red bags inside filled over 10 inches above the top of the box. In the lounge area were five 36 inches by 25 inch medical waste disposal cardboard box container with red bags over full with used yellow gowns, gloves, and mask. Additionally, in the lounge was a large red bag open with used food serving containers, cups, and milk cartons. Continued observation on 7/12/22, 200 unit currently occupied by 12 resident who are in quarantine for COVID-19 was found to: " All the lights in the hallway were shut off causing very low light throughout the hallway. " Dirt, gloves, and papers were found lying on the hallway floor. " Four rooms had stacked up hospital bed frames, mattress, bedside stands. " A strong odor of feces, urine, and garbage filled the air. " The residents' room in Unit 200, hallway, and lounge were warm and humid. No air flow from ventilation systems and the large metal industrial fan was not turned on. " Patient lift and sit to stand equipment located on the right side of the hallway. On the left side of the hallway blocking the hand railing was a	21665		

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21665	Continued From page 33 large covered linen cart, one three tier cart on wheels, and a three-tier cart filled with body soap, lotion, and lotion. A three-tier cart with incontinent products on the top shelf. Three tier carts with a blue pitcher of water. Three-quarters of the handrails were inaccessible throughout the unit due to being blocked by equipment and other items. " All twelve of the occupied residents' room were found to have visible dirt, dust, spill stains from liquids, and garbage. On 7/12/22, at 9:15 a.m. nursing assistant (NA) - B stated, "it is so warm in here, I keep sweating, and the residents had complained about the heat." NA-B further stated, "the nasty smell of garbage just lingers because no one had taken out the garbage". NA-B stated this is not healthy for the residents, especially with the heat and no air flow. NA-B further stated she reported the concerns about the heat on Friday, but no facility staff had come to investigate. On 7/12/22, at 1:45 p.m. during observation of the 200-unit malodorous smell of garbage filled the hallway and lounge. Found in the lounge were five 36 inches by 25-inch medical waste disposal cardboard box container with red bags over full of used yellow gowns, gloves, and mask. Additionally in the lounge was large red bag filled with used disposable food serving containers with uneaten food, open cartons of milk, and cups. On 7/12/22, at 1:50 p.m. during interview nursing assistant (NA)-B stated she had been the only staff working in this unit except for when the nurse went on the unit to pass medication. NA-B, stated "it smells so bad, and the garbage is piling up, I use the deodorizer to help." NA-B further stated this is not healthy or safe for these	21665		

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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**

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21665	Continued From page 34 residents on this unit. NA-B stated she had not seen housekeeping staff come onto the unit to clean. NA-B further stated, it felt like the other staff avoid this area because it was the COVID-19 unit. On 7/13/22, at 8:33 a.m. during observation of the 200 unit in the hallway outside room 212 was a large red bag opened with found used disposable food serving containers with uneaten food, open cartons of milk, and cups. The facility's TELS Work Order report dated 7/13/22, lacked indication concerns regarding the heat in the 200 unit and the air conditioner not working. On 7/13/22, at 9:12 a.m. Regional Environmental Service Director (ESD) stated the facility did not have a policy for proper containment or removal of garbage. ESD stated housekeeping staff working with the nursing staff should have removed or disposed of the refuse as needed and should not be left in the hallways for health and safety reasons. ESD further stated the facility is using a contracted housekeeping staff and would need to follow up with removing the garbage off the unit. A facility policy was requested none was provided. On 7/13/22, at 2:00 p.m. the director of nursing (DON) stated it is the responsibility of the nursing and housekeeping staff to ensure garbage is removed off the unit and not piled up in the hallways. DON further stated staff should not put open bags of food containers, bags of personal protective equipment, and bags of soiled clothing and towels on the floors in the hallway for health and safety reason. DON further stated her expectations for staff to ensure the hallways are	21665		

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21665	Continued From page 35 kept free of garbage, and the garbage is removed as needed so it would not pile up. On 7/13/22, at 6:25 p.m. administrator stated she was made aware of the warm temperatures concerns in the 200 unit on 7/8/22. The administrator further stated the HVAC mechanical serviceman assessed the issues with the air conditioning unit on 200 unit and found a broken belt and a blown fuse. A facility policy on safe, clean homelike environment was requested but not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21665		