Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 2, 2023

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

RE: CCN: 245320
Cycle Start Date: September 6, 2023

Dear Administrator:

On September 28, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 14, 2023

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

RE: CCN: 245320
Cycle Start Date: September 6, 2023

Dear Administrator:

On September 6, 2023, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 6, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 6, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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September 14, 2023

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

Re: Event ID: LHHB11

Dear Administrator:

The above facility survey was completed on September 6, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 09/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/1/23, 9/5/23, and 9/6/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H53204827C (MN00096253) H53204845C (MN00096200) H53205166C (MN00096068) H53205168C (MN00096476) H53205167C (MN00092422) As a result of the investigation a deficiency was issued at F697. 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 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		9/25/23

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

Electronically Signed | 09/22/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 697	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and records review, the facility failed to thoroughly assess pain and implement orders for pain management for 1 of 1 resident (R2) reviewed who was suffering from headaches and prescribed tramadol. Findings include: R2's admission Minimum Data Set (MDS) dated 7/23/23, showed an admission date of 7/17/23. The MDS indicated R2 had moderate cognitive impairment, with active diagnoses including fractures and other multiple traumas, cancer, hypertension, and dementia. The MDS also indicated R2 was frequently in moderate pain and receiving pain medications. R2's care plan identified R2's alteration in thought processes as evidenced by deficits in memory/recall ability, judgment, decision making, and thought processes. The care plan directed staff to observe, document, and report to medical practitioner any changes in cognitive function. The care plan indicated R2 had potential for actual communication problem with difficulty expressing ideas/wants. The care plan indicated R2's preference to communicate face to face while family present, actual/potential for pain with need for medication management, and for staff to monitor and report any increase in frequency of pain or discomfort. The care plan noted interventions for staff to observe and document verbal and non-verbal signs of pain but did not provide direction for medication management. R2's orders summary report (OSR) dated 8/23, directed staff to give Tylenol 650 milligrams (mg)	F 697	Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F697, Pain Management. Woodlyn Heights Senior Living corrected the deficiency by assessing all residents to ensure their pain was assessed and orders for pain management were in placed by 9/20/2023. All residents' charts were reviewed for accuracy of orders by DON and Nurse Managers on 9/7/2023. Reeducation was provided to licensed nursing staff on transcribing physicians orders, post fall assessments and monitoring on 9/12/2023. R2 discharged from facility. 2. To correct the deficiency and to ensure the problem does not recur all licensed	

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F 697	Continued From page 2 by mouth every six (6) hours as needed for mild pain, and give Norco (hydrocodone-acetaminophen) 5-325 mg one (1) tablet by mouth every six (6) hours as needed for moderate pain. R2's medication administration record (MAR) for the month of August 2023 (8/1/23 to 8/9/23), showed the trend for R2's increased need of pain medication, as follows: -8/1/23, Norco 5/325 mg -8/2/23, Norco 5/325 mg -8/3/23, No pain medication -8/4/23, Tylenol 650 mg and Norco 5/325 mg -8/5/23, Norco 5/325 mg -8/6/23, Tylenol 650 mg and Norco 5/325 mg (2 times) -8/7/23, Tylenol 650 mg and Norco 5/325 mg (2 times) -8/8/23, Tylenol 650 mg and Norco 5/325 mg at 7:52 a.m. (ineffective) -8/9/23, Tylenol 650 mg and Norco 5/325 mg at 7:38 a.m. (ineffective) The progress notes entered on 8/4/23 at 7:06 p.m., indicated R2 had an unwitnessed fall. The notes also indicated staff completed R2's assessment and found no injuries. There was lack of evidence to show subsequent assessment/monitoring after the immediate or initial post fall assessment. The MD (medical director) Note dated 8/6/23, indicated physician encounter with R2 where R2 complained of headaches that lasted for five days (previous to fall). The MD Note also indicated plan to start tramadol 50 mg twice a day for five (5) days. The progress notes entered on 8/9/23, indicated R2 complained of headache but that R2	F 697	nursing staff were educated on 9/20/2023 or prior to their next scheduled shift on pain assessments and management by Kiara Marshall, DON. 3. The DON and/or designee will audit all fall incidents for appropriate post fall pain assessments and management 3x/week for 4 weeks, then 2x/week for 8 weeks, and then as needed to ensure continued compliance. The DON and/or designee will audit all new orders for accuracy 5x/week for 4 weeks, 2x/week for 8 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 697	Continued From page 3 did not know why he was having a headache, and was sent to the hospital upon family request. A document titled, Physician Orders, showed an order signed and dated 8/6/23 to give R2 tramadol 50 mg BID (twice a day) prn (as needed) x three (3) days for headache. The NP (Nurse Practitioner) Note dated 8/7/23, indicated nurse practitioner's (NP) visit to address R2's headaches that reportedly lasted intermittently for eight days (previous to fall). The NP Note also indicated that the tramadol 50 mg was re-ordered electronically because the physician's order dated 8/6/23 was not processed. However, R2's OSR for August 2023 did not include the newly added order for pain medication, tramadol 50 mg. In addition, the MAR for August 2023, did not show the pain medication (tramadol 50 mg) as planned and ordered. During interview on 9/5/23 at 9:50 a.m., registered nurse (RN)-A stated she was the nurse for R2 when he had an unwitnessed fall on 8/4/23. RN-A stated R2 did not have any injuries, denied having hit his head, and denied pain. When asked to verify that she administered Norco 5/325 mg (for moderate pain) to R2 on 8/4/23 at 9:13 p.m., RN-A replied she does not remember but stated she "might have given it for comfort." RN-A also verified she had not completed any documentation regarding R2's pain nor started any neuro-assessments following his unwitnessed fall but had passed a verbal report to the oncoming night nurse.	F 697		

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F 697	Continued From page 4 During interview on 9/5/23 at 1:04 p.m., RN-B verified she worked on the overnight shift on 8/4/23, or immediately following the evening of R2's fall. However, RN-B stated she could not remember R2's fall nor any complaints of head pain during her shift. RN-B stated that "sometimes reports are not clear, so I go back to read documentation, and by the way they found him, he had no injuries." RN-B also stated if she gave pain medication, R2 must have asked for it but she could not remember if she asked where the pain was. RN-B verified she did not document any follow-up pain or neuro-assessments related to R2's unwitnessed fall. During interview on 9/5/23 at 1:36 p.m., RN-C stated she took care of R2 in the morning shifts of 8/5/23 and 8/6/23. RN-C verified she gave pain medications to R2 but did not specifically ask what was painful. RN-C stated she assumed it was for R2's back because he always had that pain and had a lidocaine patch there. RN-C also stated she did not monitor R2 for head pain because she was not aware of the recent unwitnessed fall on 8/4/23. During interview on 9/5/23 at 4:21 p.m., RN-E verified he was the nurse for R2 in the evening of 8/7/23 and gave pain medication for his back. RN-E said he was not aware R2 had a fall on 8/4/23 and was not aware R2 had been complaining of headaches. During interview on 9/5/23 at 9:28 a.m., NA-D stated she worked as a medication aide on 8/8/23 and 8/9/23, and R2 asked for pain medications but she did not ask R2 to specify what was painful. NA-D said, I only asked him to rate the pain from one to 10 and he said it was really bad	F 697		

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F 697	Continued From page 5 at seven, eight so I gave him [pain medication]." NA-D stated she did not know R2 had a fall on 8/4/23. During interview on 9/5/23 at 1:34 p.m. RN-F stated she was the nurse for R2 on 8/9/23 and did not know R2 had a recent fall. RN-F stated R2 was complaining of a headache, and the family was there asking that R2 be sent to the hospital. RN-F also stated, "The doctor was there too and sent him to the hospital." During interview on 9/5/23 at 3:49 p.m., family member (FM)-A stated R2 already passed away and his death certificate listed subarachnoid hematoma related to accident. FM-A provided a copy of R2's death certificate, which showed the immediate cause of death was complication of subdural hematoma, underlying closed head injury, fall to floor. FM-A stated R2 had been complaining of headache getting worse and nothing had been done. FM-A stated nobody thought of sending R2 to the hospital for evaluation, and FM-A said, "They called the doctor to try tramadol, but I don't know if they even got that." During interview on 9/5/23 at 4:45 p.m., director of nursing (DON) stated that staff should do a focused fall assessment to determine symptoms related to the fall such as pain (location), and then alleviate the pain. The DON stated that if pain is not resolved or gets worse, then report to the NP. The DON acknowledged that it was R2's family who reported to her and NM-A that R2 had increased pain after the fall, which nurse manager (NM)-A then communicated to the NP. The DON verified lack of documentation to show follow-up assessments, interventions, and/or	F 697		

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F 697	Continued From page 6 notification to the NP. During interview on 9/6/23 at 9:37 a.m., NM-A stated, "When [R2] was complaining of headache, we gave him Tylenol, but those medications were not working- and then we gave him tramadol." However, after reviewing R2's OSR and MAR, NM-A verified that there was no tramadol listed. At 10:30 a.m., the NM-A verified R2 did not receive tramadol as ordered. During interview on 9/6/23 at 10:53 a.m., the NP indicated she was aware of the fall and the headaches. The NP stated that the headaches pre-dated the fall because R2 reported to her about having headaches for 8 days during her visit on 8/7/23. The NP stated she did her own assessment and R2 was fine neurologically (no deficits indicative of brain bleeding) at that time (8/7/23) except the headache. The NP stated the facility sent R2 to the hospital when he started to talk in circles and demonstrated a change in condition on 8/9/23. The NP also stated there was an order for tramadol to address the headache which should have been started have been started on 8/7/23 and was not. NP indicated this would have assisted R2 with his pain, adding, "I told the nurse to give because he was complaining of a headache." During interview on 9/6/23 at 12:30 p.m., The DON acknowledged the importance of thorough assessments and interventions, following best practice guidelines. The DON also acknowledged the importance of following orders for pain management. The DON verified that staff did not administer the tramadol for pain management as ordered for R2.	F 697		

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F 697	Continued From page 7 Facility protocols related to fall was requested but the administrator indicated the facility did not have one aside from the document titled, Risk Management, dated 10/25/21, which does not provide specific guidelines for staff to follow after a fall incident including focused pain assessments, interventions, and monitoring. The policy titled, Medication Orders, revised on 11/18, provides that nurse on duty will at the time a new handwritten order is received, will enter it in the electronic medical records and notes the order.	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00829	A. BUILDING: _____ B. WING _____	C 09/06/2023

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WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/1/23, 9/5/23, and 9/6/23, a complaint survey was conducted at your facility by surveyor from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00829	A. BUILDING: _____ B. WING _____	C 09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 H53204827C (MN00096253) H53204845C (MN00096200) H53205166C (MN00096068) H53205168C (MN00096476) H53205167C (MN00092422) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		