Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 22, 2024

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

RE: CCN: 245320
Cycle Start Date: July 17, 2024

Dear Administrator:

On August 1, 2024, we notified you a remedy was imposed. On August 20, 2024 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 11, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 16, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 1, 2024, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 16, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 11, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 22, 2024

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

Re: Reinspection Results
Event ID: FV6C12

Dear Administrator:

On August 20, 2024 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 17, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 1, 2024

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

RE: CCN: 245320
Cycle Start Date: July 17, 2024

Dear Administrator:

On July 17, 2024, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant 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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 16, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 16, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 16, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $12,924; 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 August 16, 2024, 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 August 16, 2024. 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)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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, Regional Operations Supervisor, Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 17, 2025 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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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://forms.web.health.state.mn.us/form/NHDisputeResolution

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,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 1, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: FV6C11

Dear Administrator:

The above facility was surveyed on July 15, 2024 through July 17, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Annette Winters, Regional Operations Supervisor, Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
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.

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

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 07/17/2024

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 7/15/24, 7/16/24, and 7/17/24, 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. H53205582C (MN00104811) with a deficiency issued at F656, F692, F695, F698, and F842. Deficient practice was identified related to incidental finding at F584. 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=D	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 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	F 584		8/11/24

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

Electronically Signed | 08/09/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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

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F 584	Continued From page 1 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 and interview, the facility failed to provide a homelike environment to two out of two residents (R2, R3) reviewed for environment. R4 had been playing his music loudly and R2 and R3 had complaints of not being able to hear their music or their televisions.	F 584	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	

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F 584	Continued From page 2 Findings Include: During an observation in the 600 hallway on 7/15/24 at 11:01 a.m., R4 had his door to his room open and loud explicit music playing. This explicit music could be heard from the front entrance of the facility as well as in the other hallways. During an observation in the 600 hallway on 7/15/24 at 12:28 p.m., R4 had his door to his room open and loud music playing. This music could be heard from the front entrance of the facility as well as in the other hallways. R2's medical records printed on 7/16/24 indicated R2 was admitted to the facility on 4/12/23 with a primary diagnosis of cerebral palsy. R2's additional diagnoses included polyneuropathy, major depressive disorder, and mild intellectual disabilities. R2's brief interview for mental status (BIMS) assessment dated 12/19/23 indicated R2 had a score of 15, which indicated R2 was cognitively intact. R3's medical records printed on 7/16/24 indicated R3 was admitted to the facility on 8/2/23 with a primary diagnosis of systemic lupus erythematosus. R3's additional diagnoses included polyneuropathy, generalized anxiety disorder, major depressive disorder, and insomnia. R3's BIMS assessment dated 11/13/23 indicated R3 had a score of 15, which indicated R3 was cognitively intact.	F 584	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 F584-Safe/Clean/Comfortable/Homelike Environment, Woodlyn Heights Senior Living corrected the deficiency by instructing R4 not to play music loudly with door open. R4 has a personal pair of headphones and was encouraged to use them. The facility interviewed R2, R3 and all like residents to ensure there were no other complaints about loud music/loud televisions. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on encouraging residents who play music or television loudly to turn music/television down to a reasonably level, shut their room door, or offer headphones for better listening and to ensure that they bring resident complaints of loud music or television to their supervisor by the Director of Nursing by 8/7/2024. The Director of Nursing and/or designee will audit R4 and all other residents for loud music or television 2x/week x 8 weeks, weekly x 4 weeks and	

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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

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F 584	Continued From page 3 R4's medical records printed on 7/16/24 indicated R4 was admitted to the facility on 1/29/24 with a primary diagnosis of orthopedic aftercare following a joint replacement or spinal surgery. R4's additional diagnoses included major depressive disorder, anxiety disorder, personality disorder, and dysthymic disorder. R4's diagnoses did not indicate R4 had hearing impairment. R4's minimum data set (MDS) dated 5/14/24 indicated R4 had a BIMS score of 14, which indicated R4 was cognitively intact. The MDS indicated R4 had adequate hearing and no hearing aides. During an interview with R2 on 7/15/24 at 12:31 p.m., R2 stated R4 had been playing his music very loud for a few days and it had been bothering her. R2 stated she told her nurse about her concerns but was unsure if staff investigated her concerns. During an interview with R3 on 7/15/24 at 12:41 p.m., R3 stated R4 started playing his music very loudly last week. R3 stated the music was bothering her as she could not hear her television very well when he was playing his music loud. During an interview with R4 on 7/15/24 at 12:55 p.m., R4 stated he had just started playing his music very loud with the door open "maybe in the last two weeks". R4 stated he had been playing his music loud because other residents were playing their music and television loud. R4 stated he was playing his music loud to anger the other residents who were playing their music and television loud. R4 stated he usually listened to his music on his headphones, but "since he paid to live there, he could play his music when he	F 584	then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living□s ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community□s QA Process. 4. The Director of Nursing is responsible for this area of compliance.	

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F 584	Continued From page 4 wanted and how loud he wanted". During an interview with the director of nursing (DON) on 7/15/24 at 3:44 p.m., the DON stated the facility creates a homelike environment by honoring the resident's wishes, cleanliness, providing a well-lite facility, ensuring the facility was free of accidents and hazards, and by creating an odor-free environment. The DON stated residents could have their music on in their rooms at a level that did not disturb other residents. The DON stated if she had heard concerns about music or noises being too loud, that she would approach the resident and ask them to turn their music or television down. The DON stated she had not heard of any complaints from residents about loud music or television. During my interview with the administrator on 7/17/24 at 4:09 p.m., the administrator stated if a resident had a concern about music or television distractions, himself, the DON, and the social worker would have a conversation with the other resident to see if they could find an alternative solution to ensure everyone's needs were being met. A policy for a homelike environment was requested and none was received.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		8/11/24

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

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F 656	Continued From page 5 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.	F 656		

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F 656	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a comprehensive care plan to meet the residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment for one of one resident (R1) reviewed for care plans. R1 was on dialysis, used tube feeding to get his nutrients, and had respiratory concerns, and activities of daily living and those care areas were not addressed on his care plan. Findings include: R1's medical records printed on 7/15/24 indicated R1 was admitted to the facility on 5/28/24 with a primary diagnosis of sepsis. R1's additional diagnoses included nondisplaced fracture of olecranon process without intraarticular extension of right ulna, hypokalemia, falls, a kidney transplant recipient, presence of a cardiac pacemaker, anemia, gastro-esophageal reflux disease, other mechanical complication of surgically create arteriovenous fistula, moderate protein-calorie malnutrition, bronchiectasis, dysphagia, end-stage renal disease, congestive heart failure, chronic obstructive pulmonary disease, age-related cataract of the right eye, peripheral vascular disease, lymphedema, osteoporosis, schizoaffective disorder, narcissistic personality disorder, and recurrent and persistent hematuria. R1's hospital records dated 5/28/24 indicated prior to R1 being admitted to the facility, he was at a hospital from 3/22/24 to 5/28/24 and diagnosed with sepsis, pneumonia, and respiratory failure. Hospital records indicated R1	F 656	1. In continuing compliance with F656 Develop/Implement Comprehensive Care Plan, Woodlyn Heights Senior Living corrected the deficiency by reviewing all resident care plans to ensure all needs identified in the comprehensive assessment are care planned by 8/11/2024. R1 was discharged from the facility on 7/8/2024. 2. To correct the deficiency and to ensure the problem does not recur the MDS Coordinators, Dietician, Social Workers, and Community Life Director were educated on ensuring needs identified in the comprehensive assessment are care planned by the Director of Nursing by 8/7/2024. The Director of Nursing and/or designee will audit 3 comprehensive care plans to ensure identified needs are care planned weekly x 12 weeks and then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living□s ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community□s QA Process. 4. The Director of Nursing is responsible for this area of compliance.	

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F 656	Continued From page 7 was dependence upon hemo-dialysis, had a CPAP machine, he was on a tube feeding program, and was on a therapeutic renal diet. Hospital records indicated R1 had a history of recurrent urinary tract infections (UTI). These hospital records were in his electronic medical record (EMR) at the facility and were obtained upon admission to the facility. R1's minimum data set (MDS) dated 6/3/24 indicated R1 admitted to the facility on 5/28/24 from a short term hospital stay. The MDS identified R1 wore corrective lenses, had a brief interview for mental status (BIMS) score of 15, which indicated R1 was cognitively intact, R1 had preferences for customary routine activities, functional limitations included impairment with lower extremity, R1 had listed functional abilities and goals, had an indwelling catheter and was frequently incontinent of bowel, R1 had diagnosis of medical complex conditions, occasional pain, had a feeding tube, was at risk for developing pressure ulcers, was taking routine antipsychotic medication, and had respiratory and dialysis needs. R1's care plan created on 5/29/24 and revised on 7/3/24 lacked the following information: -R1 was on anti-psychotic medications. The intervention was to attempt non-pharmacological interventions and to observe for effectiveness. The care plan did not indicate what non-pharmacological interventions should be used. -Did not indicate R1's cognitive status including R1's BIMS score and how R1 communicates. -Did not indicate R1's preferences for customary routines and activities or whether R1 likes to pursue activities as a group or individually.	F 656		

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F 656	Continued From page 8 -The care plan did not indicate R1's bathing preferences and frequency, or oral cares including whether R1 had his own teeth or dentures. -R1's care plan did not indicate R1 was at risk for urinary tract infections due to his supra pubic catheter and urinary and bowel incontinence. -R1's care plan did not indicate how R1 ambulates, including a wheelchair, walker, side rails, or grab bars. -R1's care plan did not indicate R1's sleep hygiene including usual sleep patterns, preferred bedtime, preferred awake time, factors contributing to poor sleep habits, or non-pharmacological interventions to promote sleep. -R1's care plan did not include R1's use of oxygen, respiratory therapy, or dialysis including frequency, location, contact information, site monitoring and care, identifying and preventing infections and complications, and what to do in event of emergency or weather-related delays in care. During an interview with the director of nursing (DON) on 7/15/24 at 3:44 p.m., the DON stated the baseline care plan is completed within forty-eight hours of the resident being admitted, then staff will complete assessments, and then the comprehensive care plan would be completed. During an interview with nursing assistant (NA)-C on 7/16/24 at 3:06 p.m., NA-C stated she would look in a resident's care plan to see how the resident is cared for. During an interview with the DON on 7/16/24 at 3:37 p.m., the DON stated a resident's COPD should be on a resident's care plan. The DON	F 656		

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F 656	Continued From page 9 stated the nursing staff and nursing management was responsible for creating a resident's comprehensive care plan. The DON stated a resident's dialysis treatment should be a part of a resident's care plan. The DON stated the interventions for a dialysis treatment should have included monitoring, the order, the date, and time the resident should be going to dialysis, restrictions, limitations, and transportation information. During an interview with the dietitian on 7/16/24 at 4:06 p.m., the dietitian stated she would create the care plan by looking at the resident's medical record and read progress notes. The dietitian stated she would expect nursing assistants to look in a resident's chart to see how the resident is cared for. During an interview with the DON on 7/17/24 at 2:26 p.m., the DON stated it is a collaborative effect with the minimum data set (MDS) coordinators and nursing management to create a resident's comprehensive care plan. The DON stated nurses are the only ones who had access to the medication administration record (MAR) and the treatment administration record (TAR), and the nurses would be the only staff members who can operate in the MAR and TAR. During an interview the MDS coordinator (MDSC)-A on 7/17/24 at 2:49 p.m., MDSC-A stated the nurses, and the nurse managements create the care plan, and he would review the care plans. MDSC-A stated he can add information to the care plan and remove things he saw fit in a care plan. MDSC-A stated when he came to a resident on tube feeding, the nurse managers create that care plan area. MDSC-A	F 656		

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F 656	Continued From page 10 stated there was a section of the MDS to check to ensure the care plan is complete. MDSC-A stated he would not go into detail when reviewing the care plan; he would just ensure the care plan is signed by the appropriate staff members. MDSC-A stated he would have a concern if a resident were on tube feedings and that information was not on a resident's care plan. MDSC-A stated if tube feeding information was not on the resident's care plan, he would ask the nurse managers to put that information into the resident's care plan. MDSC-A stated the same thing would be true if a resident was on dialysis. MDSC-A stated he would expect a resident's pertinent diagnoses to be put in a resident's care plan, including tube feeding, dialysis, and any complications that would go with those diagnoses. During an interview with MDSC-B on 7/17/24 at 3:13 p.m., MDSC-B stated if there was a significant change with a resident, she would expect the nurse managers to assist in assessing the resident. MDSC-B stated she would expect dialysis to be on a resident's care plan and what type of dialysis access the resident had. MDSC-B stated she would expect a resident's tube feeding information to be on a resident's care plan. MDSC-B stated she would expect the dietitian to put in a resident's tube feeding information into the resident's care plan. MDSC-B stated after assessments were completed, she would typically sign off on the nursing parts of the care plan, but stated the whole care plan was nursing related. During an interview with the administrator on 7/17/24 at 4:09 p.m., the administrator stated his expectations would be for the care plan to be created by the interdisciplinary team. The	F 656		

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F 656	Continued From page 11 administrator stated when a resident was admitted to the facility, or if there was a significant change in the resident, the facility needed to ensure the resident had everything they needed to thrive, and that protocols and assessments were in place. The administrator stated he would expect dialysis and tube feeding information to be on a resident's care plan. The facility policy titled "Person Centered Care Plan" created on 1/2023 and revised on 10/2017 indicated the baseline care plan should include, but not limited to, physician orders, therapy orders, a summary of the resident's medications and dietary instructions, any services, and treatments to be administered by the facility and personnel acting on behalf of the facility, and any updated information based on the details of the comprehensive care plan. The policy stated the comprehensive person-centered care plan should contain "measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments. The policy stated the overall person-centered care plan should be orientated towards preventing avoidable declines, management of risk factors, preserving and building on a resident's strength's, respecting a resident's personal preferences, include specific care goals, treatment preferences, and desired outcomes of care, and to include a resident's strengths and care needs. The policy stated an area to address on the comprehensive care plan is a resident's cognitive status including current BIMS score, how a resident makes self-understood, and how the resident understands. The policy stated an area to address on the comprehensive care plan is a resident's behavior including	F 656		

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F 656	Continued From page 12 non-pharmacological interventions, and psychoactive medication class along with the appropriate diagnosis or indication for use. The policy stated an area to address on the comprehensive care plan is mood which includes PHQ-9 score, target behaviors, and non-pharmacological interventions. The policy stated an area to address on the comprehensive care plan is activity pursuit including preferences for customary route and activities, and whether the resident likes to pursue activities as a group or independently. The policy stated an area to address on the comprehensive care plan is hygiene including bathing preferences and frequency, and oral care including if the resident had their own teeth or dentures. The policy stated an area to address on the comprehensive care plan is elimination including risk for urinary tract infections. The policy stated an area to address on the comprehensive care plan is all current acute and chronic clinical conditions for which the resident was receiving medications, treatments, and/or care, which may include but not limited to COPD, heart disease, and infections. The policy stated an area to address on the comprehensive care plan is mobility and fall risk including a resident's mobility, and devices used such as a walker, wheelchair, grab bars, and side rails. The policy stated an area to address on the comprehensive care plan is sleep hygiene which includes usual sleep pattern, preferred bedtime, preferred wake time, factors contributing to poor sleep habits, non-pharmacological interventions to promote sleep, and sleep monitoring. The policy stated an area to address on the comprehensive care plan is special treatments and procedures including oxygen. The policy stated an area to address on the comprehensive care plan is respiratory therapy including short of	F 656		

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F 656	Continued From page 13 breath when resting, with activity, or when lying flat. The policy stated an area to address on the comprehensive care plan is dialysis including frequency, location, contact information, site monitoring/care, identifying/preventing infections, and complications, and what to do in an event of emergency or weather-related delays in care. The facility policy titled "Dialysis Care Plan and Treatment Sheet" policy and procedure effective 2/2019 stated the dialysis care plan should include the name of the dialysis location with the phone number, the days the resident is scheduled to receive dialysis, monitoring for complications following dialysis including hypotension, febrile reaction, bleeding, and infection, emergency measures, fluid restrictions including measured intake and for nursing to monitor for compliance or non-compliance, precautions to include, monitoring the vascular access including to check bruit and thrill, checking for redness, edema, and drainage position, monitoring weight and vital signs, send a meal/snack to dialysis, shunt dressings to be changed, what to do if a resident refuses to go to dialysis, and to monitor emotional status and provide psychosocial interventions as indicated.	F 656		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		8/11/24

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F 692	Continued From page 14 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to monitor and assess the hydration status for one of one resident (R1) reviewed for hydration. R1 had an order for tube feedings with direction to adjust the free water flushes pending hydration status one time a day and facility staff were not monitoring or assessing R1's hydration status. Findings include: R1's medical record printed on 7/15/24 indicated R1 was admitted to the facility on 5/28/24 due to sepsis. R1's additional diagnoses included hypokalemia, moderate protein-calorie malnutrition, bronchiectasis, dysphagic, chronic obstructive pulmonary disease (COPD), gout, and lymphedema. R1's hospital discharge papers dated 5/22/24 indicated R1 had a gastrostomy-jejunostomy placed on 5/18/24. The record indicated R1 was on tube feedings with an oral diet. The record indicated R1 was on a Novasource Renal diet	F 692	1. In continuing compliance with F692-Nutrition/Hydration Status Maintenance, Woodlyn Heights Senior Living corrected the deficiency by having the Dietician review all residents receiving tube feedings for appropriate hydration status. All residents receiving tube feedings had hydration monitoring added to their treatment administration record on 8/9/2024. R1 was discharged from facility on 7/8/24. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated on hydration status monitoring and physician notification by the Director of Nursing by 8/7/2024. The Director of Nursing and/or designee will audit all tube fed residents for proper hydration monitoring weekly x 12 weeks and then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living□s ongoing commitment to quality	

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F 692	Continued From page 15 administered at one hundred twenty milliliters (mL) per hour for nine hours. The record indicated R1 was to receive thirty mL before and after each feeding. The record indicated R1's estimated calorie needs were one thousand twenty to two thousand ninety per day. R1's admission record indicated R1 was not on fluid restrictions but was on moderately thick liquids. R1's treatment administration record (TAR) dated 7/2/24 indicated R1 was to receive tube feeding for Novasource Renal at one hundred twenty mL per hour for nine hours a day via percutaneous endoscopic gastrostomy (PEG)- J tube with thirty milliliters (mL) free water flushes every six hours via both G and J ports. The TAR indicated to adjust the free water flushes pending hydration status one time a day. The TAR indicated this was discontinued on 7/9/24. R1's progress note dated 7/2/24 written by the dietitian indicated R1 received Novasource one hundred twenty mL per hour for nine hours overnight and if not tolerated to reduce to ninety mL per hour over twelve hours over night but that nursing had reported tolerating at one hundred twenty mL per hour at that time. The progress note indicated water flushes with thirty mL of water four times a day. The progress note indicated to adjust free water flushes pending hydration status. The progress note indicated R1 was to receive nutrisource fiber oral packet directed at one packet via G-tube three times a day for constipation with flush tube with fifteen mL water before, mixing the nutrisource fiber oral packet with sixty to one hundred twenty mL water until dissolved, then flushing the tube with thirty to sixty mL of water after.	F 692	assurance, the Director of Nursing and/or designee will report identified concerns through the community□s QA Process. 4. The Director of Nursing is responsible for this area of compliance.	

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F 692	Continued From page 16 R1's hospital records from 7/8/24 indicated when R1 was seen by the provider in the emergency department, R1's mucous membranes were dry and was unable to tolerate secretions. The hospital records indicated R1 would require aggressive fluid resuscitation. During an interview with R1's guardian on 7/15/24 at 1:55 p.m., the guardian stated she visited R1 at the dialysis center on 7/8/24 and the dialysis nurse (DN) had called an ambulance because R1 was so dehydrated they could not dialyze him. The guardian stated R1 was partially responsive. The guardian stated DN called for an ambulance and R1 was sent to the hospital. During an interview with nursing assistant (NA)-C on 7/16/24 at 3:06 p.m., NA-C stated she had fed R1 around 8:00 a.m. on 7/8/24. NA-C stated R1 ate about 5% of his food and had about two hundred forty mL. NA-C stated about ten minutes after she fed R1, R1 had vomited. During an interview with the director of nursing (DON) on 7/16/24 at 3:37 p.m., the DON stated she hadn't personally assessed or seen R1 dehydrated. The DON stated the dietitian, and the facility provider will determine the need for an increase or decrease in the amount of free water flushes were given to R1. The DON stated the nursing staff would be monitoring R1's fluid intake. The DON stated the fluid intake documentation in R1's tasks only included fluids R1 drank orally, and staff would document the free water flushes on the TAR and MAR. During an interview with the dietitian on 7/16/24 at 4:06 p.m., the dietitian stated she would be responsible for tracking R1's nutritional needs,	F 692		

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F 692	Continued From page 17 including his fluid intake. The dietitian stated she was responsible for determining R1's hydration status. The dietitian stated she had thought R1 was meeting his nutritional needs. The dietitian stated she would adjust the free fluid flushes if she heard from the nursing staff stating he may have needed an adjustment. The dietitian stated R1 had not presented to her with dehydration. The dietitian stated she would chart on feeding tube nutritional values monthly. During an interview with the DON on 7/17/24 at 2:26 p.m., the DON stated the interdisciplinary team met with the dietitian and discussed that R1 was not taking any fluids or foods orally and the dietitian looked at R1's current "situation" and deemed R1 was getting sufficient calories. During an interview with the administration on 7/17/24 at 4:09 p.m., the administrator stated he would expect when it came to hydration status, that the staff would do a care conference with R1 and his family and note any significant changes. The administrator stated he would expect that hydration status would be monitored daily. A policy on assessing hydration status and needs were requested and none was provided.	F 692		
F 695 SS=G	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		8/11/24

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F 695	Continued From page 18 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the ordered respiratory care and obtain an order to administer oxygen for one of one resident (R1) reviewed for respiratory status. R1 was harmed when he was admitted to the facility with an order to provide respiratory chest physiotherapy three times a day, was not provided the ordered therapy, contributing to R1's death. In addition, R1 received oxygen therapy without a physician order. Findings include: R1's medical record indicated R1 was admitted to the facility on 5/28/24 with a primary diagnosis of sepsis. R1's additional diagnoses included bronchiectasis, dysphagia, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD). R1 was discharged from the facility on 7/10/24. R1's hospital discharge summary dated 5/28/24 indicated R1 was inpatient from 3/22/24 to 5/28/24. R1's admitting diagnosis was respiratory failure with hypoxia, including acute kidney injury, delirium, pneumonia, two-time renal transplant, hypertensive heart and chronic kidney disease with heart failure and unspecified stage chronic kidney disease, hypothyroidism, anemia, pacemaker cardiac status, immunodeficiency due to drugs, congestive heart failure, urinary retention, schizoaffective disorder (chronic), and infection and inflammatory reaction due to cystostomy catheter. R1 was diagnosed with severe sepsis from Escherichia coli (E. coli) and	F 695	1. In continuing compliance with F695-Respiratory/Tracheostomy Care and Suctioning, Woodlyn Heights Senior Living corrected the deficiency by reviewing all residents with respiratory orders to ensure orders are accurate and being followed as ordered. All residents orders were reconciled from 7/1/2024. R1 was discharged from the facility on 7/8/24. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated on following physician orders, documenting PRN oxygen orders, reviewing all discharge documents for orders, filling out the Nursing Admission Assessment correctly, completing pre/post dialysis assessments, documenting vital signs correctly, and ensuring a thorough respiratory assessment is completed before/after nebulizer treatments by the Director of Nursing by 8/7/2024. The Director of Nursing and/or designee will audit 3 residents with respiratory orders to ensure orders are accurate and being followed weekly x 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit 3 residents with PRN oxygen orders for correct documentation weekly x 12 weeks and then randomly to ensure continued compliance. The Director of	

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F 695	Continued From page 19 Enterobacter cystitis in the setting of suprapubic catheter with possible component of community-acquired pneumonia. R1's hospital course was complicated by recurrent episodes of transient hypoxia thought to be due to either mucus plugging or recurrent aspiration events. R1 continued to have these episodes despite transition to jejunal feeds and while taking nothing by mouth (NPO). R1 was on a modified diet for dysphagia and had scheduled dialysis. R1's heath was improving, and he was free of communicable disease. It was determined R1 required skilled nursing care. Respiratory therapy recommendations included DuoNebs followed by Hypertonic saline nebulizers three times a day done simultaneously with chest vest therapy (Also called chest physiotherapy. Chest physiotherapy is a treatment used to improve breathing by the indirect removal of mucus from the breathing passages.) The facility was to ensure nebulizer was cleaned daily. R1's treatment administration record (TAR) dated 5/29/24 indicated nursing was to complete a pre-and-post dialysis assessment before dialysis and on return from dialysis on Mondays, Wednesdays, and Fridays. The pre-dialysis assessment included vital signs, level of consciousness, if the resident had experienced any muscle cramping, itching, discomfort, or pain, and if there was a thrill and bruit noted. The post-dialysis assessment included vital signs, if the resident had experienced any dizziness, nausea, vomiting, fatigue, chills, shaking, muscle weakness, skin flushing, itching, or diarrhea, if there was a thrill and bruit noted, and a place to enter access site notes. On 7/8/24, the TAR signed by registered nurse (RN)-A indicated the pre-and-post dialysis assessment was completed	F 695	Nursing and/or designee will audit 3 residents for correct vital signs documentation weekly x 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit 2 new resident admissions for accurate order completion and accurate completion of the Nursing Admission Assessment weekly x 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit 3 residents with dialysis for pre/post dialysis assessment completion weekly x 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit 3 residents with nebulizer treatments for thorough respiratory assessment weekly x 12 weeks and then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living□s ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community□s QA Process. 4. The Director of Nursing is responsible for this area of compliance.	

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F 695	Continued From page 20	F 695		

but an assessment was not completed. The pre-and-post dialysis assessment had only been completed on 6/10/24, 6/17/24, and 6/19/24 during his admission.

R1's progress note written by the social worker (SW) on 5/30/24 at 1:39 p.m. indicated the SW was working on getting an order for the vest.

R1's medical record indicated no documentation regarding R1's chest physiotherapy vest, the order for the chest physiotherapy vest, or treatments between 5/30/24 and 6/11/24.

R1's minimum data set (MDS) dated 6/3/24 indicated R1 had asthma, COPD, or chronic lung disease such as chronic bronchitis. The MDS indicated R1 received zero days of respiratory therapy for fifteen minutes in the last seven days.

R1's provider visit notes dated 6/7/24 indicated R1 had not been getting his percussion vest treatments and the provider had educated nursing staff on the vest treatments. The provider indicated R1 was to have his percussion vest used "routinely".

R1's progress note written by the SW on 6/11/24 at 2:21 p.m., the SW stated R1 has orders for a vest.

R1's physician order dated 6/14/24 indicated staff to administer oxygen two liters as needed via nasal canula.

R1's TAR dated 6/14/24 indicated R1 was to use oxygen as needed at two liters per minute via nasal cannula as needed for shortness of breath and to record rate as needed. This treatment was

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F 695	Continued From page 21 not signed off by nursing staff from 6/14/24 to the time R1 was discharged. The TAR indicated staff was to obtain R1's oxygen level and to record the results every shift. R1's TAR indicated nursing staff was to ensure that R1's portable oxygen tank was filled prior to use of "N.O.". R1's TAR indicated nursing was to check oxygen tubing and set up for usage weekly on the night shift and replace it is had been used. R1's physician orders dated 6/24/24 indicated R1 was to receive vest treatment therapy every night with nebulizer treatment for bronchiectasis. There was no summary of the provider visit with R1 or the provider assessing R1's lung sounds. R1's TAR dated 6/24/24 indicated R1's "Pul" vest was to be used every night with his nebulizer treatment for fifteen minutes one time a day. The dates this treatment was completed was 6/24/24, 6/25/24, and 6/26/24. This order was discontinued on 6/28/24 when R1 was hospitalized for an unrelated fall. R1's hospital discharge record indicated R1 was admitted to the hospital from 6/27/24 to 7/1/24 after a witnessed fall. R1's admitting diagnosis was a fall including closed fracture of proximal end of right ulna, laceration of left lower extremity, hypomagnesemia, hypophosphatemia, acute hypokalemia, cardiac pacemaker, dysphagia, end stage renal disease, closed fracture of right olecranon process, hypotension, malnutrition, hypovolemia, and anemia. Assessments indicated R1 had crackle/coarse and expiratory wheezes in all lobes of R1's lungs. During R1's hospitalization, respiratory therapy administered R1's nebulizer and performed chest physiotherapy. R1 was to continue with his vest	F 695		

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F 695	Continued From page 22 therapy and saline nebulizers and DuoNebs as ordered. R1's medication administration record (MAR) dated 7/1/24 indicated R1 was to receive ipratropium-albuterol inhalation solution with the directions to inhale 3 milliliters (mL) orally via nebulizer three times a day for shortness of breath. The order indicated for staff to listen to R1's lungs and to record if R1's lungs were clear, crackles, wheezes, rales, or rhonchi. R1's brief interview for mental status (BIMS) dated 7/2/24 indicated R1 had a score of 14, which indicated R1 was cognitively intact. R1's Admission/Readmission and Care Plan Nursing Assessment dated 7/3/24 indicated R1 was not on a nebulizer, R1 did not have oxygen needs, and R1 had "normal" lung sounds. R1's progress note written by the nurse manager (NM) on 7/3/24 at 4:58 p.m. indicated R1 did not have any respiratory devices. R1's vital signs documented on 7/8/24 at 2:19 a.m., indicated R1's respirations were twenty breaths per minute, ninety-four percent oxygen on room air, blood pressure was one hundred ten over seventy millimeters of mercury (mmHg) while lying and the blood pressure was taken on his right arm, pain level was zero, pulse was eighty-four beats per minute, and temperature was ninety-six point nine degrees Fahrenheit taken by tympanic. R1's vital signs documented on 7/8/24 at 2:01 p.m. indicated R1's oxygen was ninety-six percent while R1 was on oxygen via nasal	F 695		

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F 695	Continued From page 23 cannula, blood pressure was one hundred twenty over seventy-four mmHg while lying and blood pressure was taken on right arm, pain score was five, pulse was seventy beats per minute, and lungs were clear. R1's temperature and respirations were not taken at this time. Medical records indicated lung sounds were clear on 7/6/24, 7/5/24, 7/4/24, 7/3/24, 7/2/24, and 7/1/24. R1's progress note dated 7/8/24 at 5:56 p.m., the NM stated he received a voicemail from the dialysis clinic that R1 had shortness of breath, so the dialysis center sent R1 to the emergency room. No additional progress notes were made on 7/8/24. R1's hospital discharge record dated 7/8/24 indicated R1 was transferred from the dialysis clinic to the hospital due to hypotension and shortness of breath. Hospital records indicated R1 was admitted to the hospital due to acute respiratory failure with hypoxia, COPD exacerbation, and pneumonia of left lower lobe due to infectious organism. The records indicated R1 was diagnosed with methicillin-resistant staphylococcus aureus (MRSA). Hospital records indicated family member (FM)-A indicated she saw R1 at the facility on 7/6/24 and at that time R1 had been visibly distressed, was concerned R1 was not getting his physiology vest treatments, appeared to be disoriented, was exhausted, and poorly cared for. The hospital records indicated R1 had bilateral significant wheezing, crackles, and had coarse sounds in his lungs. Hospital records indicated R1 had respiratory symptoms "brewing" for a few days. The hospital records indicated R1 had a history of mucous plugging and was unclear whether he was getting his chest physiotherapy at the facility.	F 695		

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F 695	Continued From page 24 Hospital records indicated R1 had severe sepsis from community acquired pneumonia, COPD, and aspiration pneumonitis. Hospital records indicated R1 was transferred to the intensive care unit (ICU). Hospital records indicated R1 continued to have increased oxygen requirements, was altered, unresponsive to questions, and unable to tolerate secretions. Hospital records indicated R1 died on 7/10/24 due to severe sepsis with shock, pneumonia of left lower lobe due to infectious organism, and acute hypoxic respiratory failure. During an interview with nursing assistant (NA)-B on 7/15/24 at 12:32 p.m., NA-B stated R1 did not have respiratory problems during his admission at the facility. During an interview with registered nurse (RN)-A on 7/15/24 at 12:49 p.m., RN-A stated he was R1's nurse on 7/8/24 and R1 had gone to dialysis that morning. Then on 7/16/24 at 2:48 p.m., RN-A stated he believed he had taken R1's vital signs on 7/8/24 but could not remember what the vital sign readings were. RN-A stated from what he remembered, R1 had been a little more tired than his baseline, but that his appearance was "nothing out of the ordinary". RN-A stated he does not remember R1's lungs being wheezy on 7/8/24. On 7/16/24 at 3:00 p.m., RN-A stated he did not see any concerns with R1 leaving for dialysis on 7/8/24. During an interview with the NM on 7/15/24 at 12:59 p.m., the NM stated R1's dialysis center called him and left a voicemail from the DN stating R1 was having shortness of breath and the dialysis center sent R1 to the hospital and directed him to follow up with the hospital. The	F 695		

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F 695	Continued From page 25 NM stated R1 never complained of shortness of breath to him. The NM stated R1 was on continuous oxygen, and he was compliant with his oxygen use. The NM stated he would perform oxygen audits on the residents to see how much oxygen residents are on versus the resident's respirations but noted he did not perform any oxygen audits on R1. During an interview with R1's guardian on 7/15/24 at 1:09 p.m., the guardian stated R1 had "issues" with his lungs where he would not cough up his mucous. The guardian stated R1 had an order for a vest treatment "weeks" prior to his admission to the facility. The guardian stated the vest treatment would help R1 get rid of the mucous in his lungs. During an interview with FM-A on 7/15/24 at 1:55 p.m., FM-A stated R1 had not been consistently receiving his vest therapy. FM-A stated she would ask R1 if he was getting his vest therapy and R1 stated he was not getting his vest therapy. FM-A stated R1 was cognitively intact. FM-A stated she visited R1 on 7/7/24 and she had asked R1 if he received his vest therapy, and he stated no. FM-A stated she had called the director of nursing (DON) and left her a voicemail stating R1 was supposed to be getting his vest therapy with his nebulizer treatments, but FM-A stated she had not received a call back. FM-A stated the respiratory specialist at the hospital prior to R1's admission to the facility stated R1's vest treatment was "key" to R1 staying alive. During an interview with the DON on 7/15/24 at 3:44 p.m., the DON stated once a resident is accepted and comes to the facility, the nurse managers who review the admission paperwork	F 695		

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F 695	Continued From page 26 and till put the orders into the resident's MAR and TAR. The DON stated her expectation was when residents were admitted to the facility with treatment orders, the orders would be transcribed, and the nurses would follow those treatment orders. The DON stated the facility was notified by FM-A that R1 was supposed to be receiving vest treatment orders but that the facility did not have an order for the vest treatments. The DON could not state when FM-A told her R1 was supposed to be receiving his vest treatments. The DON stated the facility received an order for the vest treatments by the in-house physician and put the vest order in R1's TAR on 6/24/24. The DON stated the order was discontinued on 6/28/24 because R1 went to the hospital. The DON stated if a resident was going to be in the hospital for over twenty-four hours, then the facility will discontinue all orders and then revisit the resident's orders when they come back from the hospital. The DON stated if she could remember, the facility did not have an order for the vest treatments when he was admitted to the facility and the facility did not have a vest treatment order prior to 6/24/24. The DON stated the vest treatment order was "missed" by the nurse managers because the "actual" order was not in R1's after visit summary from his hospitalization from 3/22/24 to 5/28/24 or his hospitalization from 6/27/24 to 7/1/24. During an interview with the DON on 7/15/24 at 4:22 p.m., the DON stated she had been trying to find a respiratory care and services policy and procedure, but she could not find one. The DON stated the facility uses the standards of care. The DON stated the facility did not have a standards of care policy or procedure.	F 695		

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F 695	Continued From page 27 During an interview with the dialysis nurse (DN) on 7/16/24 at 9:13 a.m. indicated R1 came to the dialysis center on 7/8/24 with labored breathing. DN stated family member (FM)-A came to the dialysis center on 7/8/24 and stated R1 was supposed to get a vest treatment for mucous plugs and R1 had been declining the weekend prior to 7/8/24. DN stated FM-A stated R1 stated he was not receiving his vest treatment. DN stated she sent R1 to the emergency department via ambulance due to his labored breathing. It is unknown whether the dialysis clinic started R1's dialysis. During an interview with the nurse practitioner (NP) on 7/16/24 at 9:23 a.m., the NP stated R1's hospital discharge paperwork from 5/28/24 indicated R1 had an order for vest therapy and her order for the vest therapy on 6/24/24 was just a "continuation of that". The NP stated when she saw R1 he stated he was supposed to be receiving his vest therapy and he was not sure the facility had an order to provide that service. The NP stated she had "just written the order for the vest treatment anyways". The NP stated the vest treatment was brought up in a conversation between R1 and herself and she had written the vest therapy order to "be safe". The NP stated she did not have access to R1's admission paperwork for a month prior to writing the vest therapy order. The NP stated if R1 had not received his vest therapy, R1's lungs would become more congested, and mucus would build up. The NP stated she would have had to consult with the pulmonary specialist about further complications R1 could have received for not receiving his vest therapy. An interview was attempted with the dialysis	F 695		

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F 695	Continued From page 28	F 695		

center on 7/16/24 at 2:31 p.m., 3:17 p.m., 7/17/24 at 9:20 a.m., 10:07 a.m., and 3:35 p.m., but the phone kept ringing and was unable to leave a voicemail.

During an interview with NA-C on 7/16/24 at 3:06 p.m., NA-C stated she did not remember R1 wheezing on 7/8/24. NA-C stated he looked very tired on 7/8/24. NA-C stated she did not remember what R1's appearance looked on 7/8/24 because she was not focused on R1's appearance. NA-C stated she and RN-A were the only ones who had interactions with R1 on the morning of 7/8/24.

During an interview with the DON on 7/16/24 at 3:37 p.m., the DON stated the nurse managers would be completing the resident's orders upon admission. The DON stated if a resident would be in the hospital for over twenty-four hours, the facility would discontinue all physician orders, but would keep the house standing orders if the resident had any. The DON stated the facility assessed R1's lung and respiratory status on 7/8/24 and his lungs were clear.

During an interview with the medical doctor (MD) who saw R1 while he was hospitalized from 7/8/24 to 7/10/24 on 7/17/24 at 9:25 a.m., the MD stated R1's missed vest treatments played a huge part in his passing. The MD stated he had severe sepsis "probably" from the pneumonia from the mucus in his lungs. The MD stated the vest treatments would have helped cleared the mucus in his lungs.

During an interview with licensed practical nurse (LPN)-A on 7/17/24 at 2:15 p.m., LPN-A stated she worked with R1 on 7/8/24 but could not tell

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

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F 695	Continued From page 29	F 695		

what R1's condition was that day. LPN-A stated she did not know R1's baseline due to her being newly employed by the facility. LPN-A stated she did not think she had any concerns with R1 on 7/8/24. LPN-A stated if she did have concerns with R1 on 7/8/24 she would have called and reported it to the physician and she does not recall having to contact the physician.

During an interview with DON on 7/17/24 at 2:26 p.m., the DON stated it would have been the nurse working with R1 on 7/8/24 that deemed him appropriate to send R1 to dialysis that day.

During an interview with RN-F on 7/17/24 at 3:02 p.m., RN-F stated R1 did not get out of bed on 7/6/24 and RN-F was concerned about it. RN-F stated R1 got out of bed on 7/7/24 because FM-A was visiting, and RN-F had no concerns.

During an interview with the administrator on 7/17/24 at 4:09 p.m., the administrator stated his expectations when it comes to a resident being admitted to the facility would be the nurses and the nurse managers will enter the orders and communicate with the pharmacy to ensure the facility had everything for that order. The administrator stated if the nurses or nurse managers had any questions or concerns with the order, his expectation would be the nurses and nurse managers would seek clarification from the provider who wrote the order. The administrator stated he would expect nurses and nurse managers to go through a resident's admission paperwork to look for treatments and medication orders prior to the resident being admitted to the facility.

A respiratory services and care policy and

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F 695	Continued From page 30 procedure was requested, and none was received.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed assess a resident before and after dialysis for one of one resident (R1) reviewed for dialysis. Findings include: R1's medical record printed on 7/15/24 indicated R1 was admitted to the facility on 5/28/24 with a primary diagnosis of sepsis. R1's additional diagnoses included a kidney transplant recipient, anemia in chronic kidney disease, end stage renal disease, and dependence on renal dialysis. R1's treatment administration record (TAR) dated 5/29/24 indicated nursing was to complete a pre-and-post dialysis assessment before dialysis and on return from dialysis on Mondays, Wednesdays, and Fridays. The pre-dialysis assessment included vital signs, level of consciousness, if the resident had experienced any muscle cramping, itching, discomfort, or pain, and if there was a thrill and bruit noted. The post-dialysis assessment included vital signs, if the resident had experienced any dizziness, nausea, vomiting, fatigue, chills, shaking, muscle	F 698	1. In continuing compliance with F698-Dialysis, Woodlyn Heights Senior Living corrected the deficiency by reviewing all residents on dialysis ensure pre/post dialysis assessment is in on treatment administration record to remind licensed nurses to complete assessment by the Director of Nursing by 8/7/2024. R1 was discharged from the facility on 7/8/24. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated on completion of pre/post dialysis assessment and ensuring treatment administration record is not signed off until assessment is completed by the Director of Nursing by 8/7/2024. The Director of Nursing and/or designee will audit 3 residents for pre/post dialysis assessment completion weekly x 12 weeks and then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior	8/11/24

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F 698	Continued From page 31 weakness, skin flushing, itching, or diarrhea, if there was a thrill and bruit noted, and a place to enter access site notes. R1's minimum data set (MDS) dated 6/3/24 indicated R1 was on dialysis. R1's medication administration record (MAR) dated 6/29/24 indicated R1 had dialysis on Monday, Wednesday, and Friday's at 11:00 a.m. R1's record review indicated three dialysis pre-and-post assessments were completed from the time of admission. The three assessments were completed on 6/10/24, 6/17/24, and 6/19/24. During an interview with registered nurse (RN)-A on 7/16/24 at 2:48 p.m., RN-A stated the pre-and-post dialysis assessments should have been done prior to R1 leaving for dialysis and when he would come back from dialysis. RN-A stated the pre-and-post dialysis assessment was "just" a "Yes" or "No" question in R1's TAR. During an interview with the director of nursing (DON) on 7/16/24 at 3:37 p.m., the DON stated the nurses should have been monitoring R1 before and after his dialysis. The DON stated the nurses should have been completing the pre-and-post dialysis assessment each time a resident goes to dialysis and when the resident comes back to the facility from dialysis. The DON stated the pre-and-post dialysis assessment consists of vital signs, level of consciousness, pain, and if the resident had a fistula, the nurses should be assessing for that. During an email correspondence between writer and administrator on 7/16/24 at 4:37 p.m., the	F 698	Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process. 4. The Director of Nursing is responsible for this area of compliance.	

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F 698	Continued From page 32 administrator stated there was not a contract between the facility and the dialysis center. During an interview with the DON on 7/17/24 at 2:26 p.m., the DON stated R1 had a TAR order to prompt the nurses to go into the resident's assessments and complete a pre-and-post dialysis assessment. The DON stated she had noticed R1 only had 3 pre-and-post dialysis assessments since he was admitted to the facility, and that was concerning to her. A dialysis assessment policy and procedure was requested, and none was received. A dialysis assessment policy and procedure was requested, and none was received.	F 698		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		8/11/24

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F 842	Continued From page 33 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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F 842	Continued From page 34 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a medical record was accurately document vital signs and assessments for one of one resident (R1) reviewed for medical records. R1's treatment administration record (TAR) indicated R1 was to have a pre-and-post dialysis assessment done three days a week and all but three of those assessments were not completed. R1's vital signs were documented while he was not in the facility. Findings include: R1's medical record indicated R1 was admitted to the facility on 5/28/24 with a primary diagnosis of sepsis. R1's additional diagnoses included bronchiectasis, dysphagia, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD). R1 was discharged from the facility on 7/10/24. R1's hospital discharge summary dated 5/28/24 indicated R1 was inpatient from 3/22/24 to 5/28/24. R1's admitting diagnosis was respiratory failure with hypoxia, including acute kidney injury, delirium, pneumonia, two-time renal transplant, hypertensive heart and chronic kidney disease with heart failure and unspecified stage chronic kidney disease, hypothyroidism, anemia, pacemaker cardiac status, immunodeficiency due to drugs, congestive heart failure, urinary	F 842	1. In continuing compliance with F842-Resident Records, Woodlyn Heights Senior Living corrected the deficiency by reviewing all residents on dialysis ensure pre/post dialysis assessment is in on treatment administration record to remind licensed nurses to complete assessment by the Director of Nursing by 8/7/2024. R1 was discharged from the facility on 7/8/24. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated on completion of pre/post dialysis assessment and ensuring treatment administration record is not signed off until assessment is completed by the Director of Nursing by 8/7/2024. The Director of Nursing and/or designee will audit 3 residents for pre/post dialysis assessment completion weekly x 12 weeks and then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process. 4. The Director of Nursing is responsible for this area of compliance.	

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F 842	Continued From page 35 retention, schizoaffective disorder (chronic), and infection and inflammatory reaction due to cystostomy catheter. R1 was diagnosed with severe sepsis from Escherichia coli (E. coli) and Enterobacter cystitis in the setting of suprapubic catheter with possible component of community-acquired pneumonia. R1's hospital course was complicated by recurrent episodes of transient hypoxia thought to be due to either mucus plugging or recurrent aspiration events. R1 continued to have these episodes despite transition to jejunal feeds and while taking nothing by mouth (NPO). R1 was on a modified diet for dysphagia and had scheduled dialysis. R1's heath was improving, and he was free of communicable disease. It was determined R1 required skilled nursing care. Respiratory therapy recommendations included DuoNebs followed by Hypertonic saline nebulizers three times a day done simultaneously with chest vest therapy (Also called chest physiotherapy. Chest physiotherapy is a treatment used to improve breathing by the indirect removal of mucus from the breathing passages.) The facility was to ensure nebulizer was cleaned daily. R1's medication administration record (MAR) dated 5/29/24 indicated R1 was to received Ipratropium-Albuterol Inhalation Solution at three milliliters (mL) inhaled orally via nebulizer three times a day for shortness of breath. The entry indicated staff was to listen and record R1's lung sounds three times a day before and after the Ipratropium-Albuterol Inhalation Solution treatment. Staff marked that the lungs were clear everyday and every time the Ipratropium-Albuterol Inhalation Solution was given except for when R1 was hospitalized from 6/27/24 to 7/1/24 and from 7/8/24 to 7/9/24. The	F 842		

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F 842	Continued From page 36 order was discontinued on 7/9/24 due to R1 being discharged. R1's treatment administration record (TAR) dated 5/29/24 indicated nursing was to complete a pre-and-post dialysis assessment before dialysis and on return from dialysis on Mondays, Wednesdays, and Fridays. The pre-dialysis assessment included vital signs, level of consciousness, if the resident had experienced any muscle cramping, itching, discomfort, or pain, and if there was a thrill and bruit noted. The post-dialysis assessment included vital signs, if the resident had experienced any dizziness, nausea, vomiting, fatigue, chills, shaking, muscle weakness, skin flushing, itching, or diarrhea, if there was a thrill and bruit noted, and a place to enter access site notes. On 7/8/24, the TAR signed by registered nurse (RN)-A stating the pre-and-post dialysis assessment was completed but an assessment was not completed. The TAR was signed off that the assessment was completed every Monday, Wednesday, and Friday except for when R1 was in the hospital from 6/27/24 through 7/1/24 and from 7/8/24 to 7/10/24. The pre-and-post dialysis assessment had only been completed on 6/10/24, 6/17/24, and 6/19/24 during his admission. R1's hospital records indicated R1 was admitted to the hospital from 6/27/24 to 7/1/24 after a witnessed fall. R1's admitting diagnosis was a fall including closed fracture of proximal end of right ulna, laceration of left lower extremity, hypomagnesemia, hypophosphatemia, acute hypokalemia, cardiac pacemaker, dysphagia, end stage renal disease, closed fracture of right olecranon process, hypotension, malnutrition, hypovolemia, and anemia. Assessments	F 842		

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F 842	Continued From page 37	F 842		

indicated R1 had crackle/coarse and expiratory wheezes in all lobes of R1's lungs. During R1's hospitalization, respiratory therapy administered R1's nebulizer and performed chest physiotherapy. The discharge exam on 7/1/24 indicated R1 had coarse bilateral lung sounds in all lobes of the lungs. It was noted R1 should continue with his vest therapy and saline nebulizers and DuoNebs as ordered.

R1's Admission/Readmission and Care Plan Nursing Assessment dated 7/3/24 indicated R1 was not on a nebulizer, R1 did not have oxygen needs, and R1 had "normal" lung sounds.

R1's progress note written by the nurse manager (NM) on 7/3/24 at 4:58 p.m. indicated R1 did not have any respiratory devices.

R1's vital signs documented on 7/8/24 at 2:01 p.m. indicated R1's oxygen was ninety-six percent while R1 was on oxygen via nasal cannula, blood pressure was one hundred twenty over seventy-four mmHg while lying and blood pressure was taken on right arm, pain score was five, pulse was seventy beats per minute, and lungs were clear. R1's temperature and respirations were not taken at this time.

R1's hospital discharge record dated 7/8/24 indicated R1 was transferred from the dialysis clinic to the hospital due at 12:52 p.m. due to hypotension and shortness of breath. Hospital records indicated R1 was admitted to the hospital due to acute respiratory failure with hypoxia, COPD exacerbation, and pneumonia of left lower lobe due to infectious organism. The hospital records indicated R1 had bilateral significant wheezing, crackles, and had coarse sounds in his

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F 842	Continued From page 38 lungs that had been "brewing" for a few days. Hospital records indicated R1 had severe sepsis from community acquired pneumonia, COPD, and aspiration pneumonitis. Hospital records indicated R1 was transferred to the intensive care unit (ICU). Hospital records indicated R1 continued to have increased oxygen requirements, was altered, unresponsive to questions, and unable to tolerate secretions. Hospital records indicated R1 died on 7/10/24 due to severe sepsis with shock, pneumonia of left lower lobe due to infectious organism, and acute hypoxic respiratory failure. ' R1's vital signs documentation indicated R1's vital signs were taking on 7/8/24 at 2:01 p.m. R1's blood pressure was one hundred twenty over seventy-four, oxygen was ninety-six percent on oxygen via nasal cannula, pain was scored at five, and pulse was seventy beats per minute. R1's temperature and respirations were not documented. During an interview with nursing assistant (NA)-B on 7/15/24 at 12:32 p.m., NA-B stated R1 did not have respiratory problems during his admission at the facility. During an interview with registered nurse (RN)-A on 7/15/24 at 12:49 p.m., RN-A stated he was R1's nurse on 7/8/24 and R1 had gone to dialysis that morning. Then on 7/16/24 at 2:48 p.m., RN-A stated he believed he had taken R1's vital signs on 7/8/24 but could not remember what the vital sign readings were. RN-A stated from what he remembered, R1 had been a little more tired than his baseline, but that his appearance was "nothing out of the ordinary". RN-A stated he does not remember R1's lungs being wheezy on	F 842		

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F 842	Continued From page 39	F 842		

7/8/24. On 7/16/24 at 3:00 p.m., RN-A stated he did not see any concerns with R1 leaving for dialysis on 7/8/24.

During an interview with the NM on 7/15/24 at 12:59 p.m., the NM stated R1's dialysis center called him and left a voicemail from the DN stating R1 was having shortness of breath and the dialysis center sent R1 to the hospital and directed him to follow up with the hospital. The NM stated R1 never complained of shortness of breath to him. The NM stated R1 was on continuous oxygen, and he was compliant with his oxygen use.

During an interview with R1's guardian on 7/15/24 at 1:09 p.m., the guardian stated R1 had "issues" with his lungs where he would not cough up his mucous.

During an interview with the dialysis nurse (DN) on 7/16/24 at 9:13 a.m. indicated R1 came to the dialysis center on 7/8/24 with labored breathing. DN stated she sent R1 to the emergency department via ambulance due to his labored breathing. It is unknown if the dialysis clinic started R1's dialysis.

An interview was attempted with the dialysis center on 7/16/24 at 2:31 p.m., 3:17 p.m., 7/17/24 at 9:20 a.m., 10:07 a.m., and 3:35 p.m., but the phone kept ringing and was unable to leave a voicemail.

During an interview with NA-C on 7/16/24 at 3:06 p.m., NA-C stated she did not remember R1 wheezing on 7/8/24. NA-C stated he looked very tired on 7/8/24. NA-C stated she did not remember what R1's appearance looked on

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F 842	Continued From page 40 7/8/24 because she was not focused on R1's appearance. During an interview with the DON on 7/16/24 at 3:37 p.m., the DON stated the facility assessed R1's lung and respiratory status on 7/8/24 and his lungs were clear. During an interview with licensed practical nurse (LPN)-A on 7/17/24 at 2:15 p.m., LPN-A stated she worked with R1 on 7/8/24 but could not tell the writer what R1's condition was that day. LPN-A stated she did not know R1's baseline due to her being newly employed by the facility. LPN-A stated she did not think she had any concerns with R1 on 7/8/24. LPN-A stated if she did have concerns with R1 on 7/8/24 she would have called and reported it to the physician and she does not recall having to contact the physician. During an interview with the administrator on 7/17/24 at 4:09 p.m., the administrator stated it is his expectation that orders are followed exactly how they are written in a resident's chart.	F 842		

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	00829	A. BUILDING: _____ B. WING _____	C 07/17/2024

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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 7/15/24, 7/16/24, and 7/17/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) were issued. Please indicate in your electronic plan of correction you	2 000		

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

Electronically Signed | 08/09/24

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H53205582C (MN00104811) with a licensing order issued at 1695, 0565, 0625 and 0940. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to develop a comprehensive care plan to meet the residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment for one of one resident (R1) reviewed for care plans. R1 was on dialysis, used tube feeding to get his nutrients, and had respiratory concerns, and activities of daily living and those care areas were not addressed on his care plan. Findings include: R1's medical records printed on 7/15/24 indicated R1 was admitted to the facility on 5/28/24 with a primary diagnosis of sepsis. R1's additional diagnoses included nondisplaced fracture of olecranon process without intraarticular extension	2 565	1. In continuing compliance with F656 Develop/Implement Comprehensive Care Plan, Woodlyn Heights Senior Living corrected the deficiency by reviewing all resident care plans to ensure all needs identified in the comprehensive assessment are care planned by 8/11/2024. R1 was discharged from the facility on 7/8/2024. 2. To correct the deficiency and to ensure the problem does not recur the MDS Coordinators, Dietician, Social Workers, and Community Life Director were educated on ensuring needs identified in the comprehensive assessment are care planned by the Director of Nursing by	8/11/24

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2 565	Continued From page 3 of right ulna, hypokalemia, falls, a kidney transplant recipient, presence of a cardiac pacemaker, anemia, gastro-esophageal reflux disease, other mechanical complication of surgically create arteriovenous fistula, moderate protein-calorie malnutrition, bronchiectasis, dysphagia, end-stage renal disease, congestive heart failure, chronic obstructive pulmonary disease, age-related cataract of the right eye, peripheral vascular disease, lymphedema, osteoporosis, schizoaffective disorder, narcissistic personality disorder, and recurrent and persistent hematuria. R1's hospital records dated 5/28/24 indicated prior to R1 being admitted to the facility, he was at a hospital from 3/22/24 to 5/28/24 and diagnosed with sepsis, pneumonia, and respiratory failure. Hospital records indicated R1 was dependence upon hemo-dialysis, had a CPAP machine, he was on a tube feeding program, and was on a therapeutic renal diet. Hospital records indicated R1 had a history of recurrent urinary tract infections (UTI). These hospital records were in his electronic medical record (EMR) at the facility and were obtained upon admission to the facility. R1's minimum data set (MDS) dated 6/3/24 indicated R1 admitted to the facility on 5/28/24 from a short term hospital stay. The MDS identified R1 wore corrective lenses, had a brief interview for mental status (BIMS) score of 15, which indicated R1 was cognitively intact, R1 had preferences for customary routine activities, functional limitations included impairment with lower extremity, R1 had listed functional abilities and goals, had an indwelling catheter and was frequently incontinent of bowel, R1 had diagnosis of medical complex conditions, occasional pain,	2 565	8/7/2024. The Director of Nursing and/or designee will audit 3 comprehensive care plans to ensure identified needs are care planned weekly x 12 weeks and then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process. 4. The Director of Nursing is responsible for this area of compliance.	

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2 565	Continued From page 4 had a feeding tube, was at risk for developing pressure ulcers, was taking routine antipsychotic medication, and had respiratory and dialysis needs. R1's care plan created on 5/29/24 and revised on 7/3/24 lacked the following information: -R1 was on anti-psychotic medications. The intervention was to attempt non-pharmacological interventions and to observe for effectiveness. The care plan did not indicate what non-pharmacological interventions should be used. -Did not indicate R1's cognitive status including R1's BIMS score and how R1 communicates. -Did not indicate R1's preferences for customary routines and activities or whether R1 likes to pursue activities as a group or individually. -The care plan did not indicate R1's bathing preferences and frequency, or oral cares including whether R1 had his own teeth or dentures. -R1's care plan did not indicate R1 was at risk for urinary tract infections due to his supra pubic catheter and urinary and bowel incontinence. -R1's care plan did not indicate how R1 ambulates, including a wheelchair, walker, side rails, or grab bars. -R1's care plan did not indicate R1's sleep hygiene including usual sleep patterns, preferred bedtime, preferred awake time, factors contributing to poor sleep habits, or non-pharmacological interventions to promote sleep. -R1's care plan did not include R1's use of oxygen, respiratory therapy, or dialysis including frequency, location, contact information, site monitoring and care, identifying and preventing infections and complications, and what to do in event of emergency or weather-related delays in care.	2 565		

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2 565	Continued From page 5 During an interview with the director of nursing (DON) on 7/15/24 at 3:44 p.m., the DON stated the baseline care plan is completed within forty-eight hours of the resident being admitted, then staff will complete assessments, and then the comprehensive care plan would be completed. During an interview with nursing assistant (NA)-C on 7/16/24 at 3:06 p.m., NA-C stated she would look in a resident's care plan to see how the resident is cared for. During an interview with the DON on 7/16/24 at 3:37 p.m., the DON stated a resident's COPD should be on a resident's care plan. The DON stated the nursing staff and nursing management was responsible for creating a resident's comprehensive care plan. The DON stated a resident's dialysis treatment should be a part of a resident's care plan. The DON stated the interventions for a dialysis treatment should have included monitoring, the order, the date, and time the resident should be going to dialysis, restrictions, limitations, and transportation information. During an interview with the dietitian on 7/16/24 at 4:06 p.m., the dietitian stated she would create the care plan by looking at the resident's medical record and read progress notes. The dietitian stated she would expect nursing assistants to look in a resident's chart to see how the resident is cared for. During an interview with the DON on 7/17/24 at 2:26 p.m., the DON stated it is a collaborative effect with the minimum data set (MDS) coordinators and nursing management to create	2 565		

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2 565	Continued From page 6 a resident's comprehensive care plan. The DON stated nurses are the only ones who had access to the medication administration record (MAR) and the treatment administration record (TAR), and the nurses would be the only staff members who can operate in the MAR and TAR. During an interview the MDS coordinator (MDSC)-A on 7/17/24 at 2:49 p.m., MDSC-A stated the nurses, and the nurse managements create the care plan, and he would review the care plans. MDSC-A stated he can add information to the care plan and remove things he saw fit in a care plan. MDSC-A stated when he came to a resident on tube feeding, the nurse managers create that care plan area. MDSC-A stated there was a section of the MDS to check to ensure the care plan is complete. MDSC-A stated he would not go into detail when reviewing the care plan; he would just ensure the care plan is signed by the appropriate staff members. MDSC-A stated he would have a concern if a resident were on tube feedings and that information was not on a resident's care plan. MDSC-A stated if tube feeding information was not on the resident's care plan, he would ask the nurse managers to put that information into the resident's care plan. MDSC-A stated the same thing would be true if a resident was on dialysis. MDSC-A stated he would expect a resident's pertinent diagnoses to be put in a resident's care plan, including tube feeding, dialysis, and any complications that would go with those diagnoses. During an interview with MDSC-B on 7/17/24 at 3:13 p.m., MDSC-B stated if there was a significant change with a resident, she would expect the nurse managers to assist in assessing the resident. MDSC-B stated she would expect	2 565		

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2 565	Continued From page 7 dialysis to be on a resident's care plan and what type of dialysis access the resident had. MDSC-B stated she would expect a resident's tube feeding information to be on a resident's care plan. MDSC-B stated she would expect the dietitian to put in a resident's tube feeding information into the resident's care plan. MDSC-B stated after assessments were completed, she would typically sign off on the nursing parts of the care plan, but stated the whole care plan was nursing related. During an interview with the administrator on 7/17/24 at 4:09 p.m., the administrator stated his expectations would be for the care plan to be created by the interdisciplinary team. The administrator stated when a resident was admitted to the facility, or if there was a significant change in the resident, the facility needed to ensure the resident had everything they needed to thrive, and that protocols and assessments were in place. The administrator stated he would expect dialysis and tube feeding information to be on a resident's care plan. The facility policy titled "Person Centered Care Plan" created on 1/2023 and revised on 10/2017 indicated the baseline care plan should include, but not limited to, physician orders, therapy orders, a summary of the resident's medications and dietary instructions, any services, and treatments to be administered by the facility and personnel acting on behalf of the facility, and any updated information based on the details of the comprehensive care plan. The policy stated the comprehensive person-centered care plan should contain "measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments. The policy stated the overall person-centered care plan should be	2 565		

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2 565	Continued From page 8 orientated towards preventing avoidable declines, management of risk factors, preserving and building on a resident's strength's, respecting a resident's personal preferences, include specific care goals, treatment preferences, and desired outcomes of care, and to include a resident's strengths and care needs. The policy stated an area to address on the comprehensive care plan is a resident's cognitive status including current BIMS score, how a resident makes self-understood, and how the resident understands. The policy stated an area to address on the comprehensive care plan is a resident's behavior including non-pharmacological interventions, and psychoactive medication class along with the appropriate diagnosis or indication for use. The policy stated an area to address on the comprehensive care plan is mood which includes PHQ-9 score, target behaviors, and non-pharmacological interventions. The policy stated an area to address on the comprehensive care plan is activity pursuit including preferences for customary route and activities, and whether the resident likes to pursue activities as a group or independently. The policy stated an area to address on the comprehensive care plan is hygiene including bathing preferences and frequency, and oral care including if the resident had their own teeth or dentures. The policy stated an area to address on the comprehensive care plan is elimination including risk for urinary tract infections. The policy stated an area to address on the comprehensive care plan is all current acute and chronic clinical conditions for which the resident was receiving medications, treatments, and/or care, which may include but not limited to COPD, heart disease, and infections. The policy stated an area to address on the comprehensive care plan is mobility and fall risk including a	2 565		

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2 565	Continued From page 9 resident's mobility, and devices used such as a walker, wheelchair, grab bars, and side rails. The policy stated an area to address on the comprehensive care plan is sleep hygiene which includes usual sleep pattern, preferred bedtime, preferred wake time, factors contributing to poor sleep habits, non-pharmacological interventions to promote sleep, and sleep monitoring. The policy stated an area to address on the comprehensive care plan is special treatments and procedures including oxygen. The policy stated an area to address on the comprehensive care plan is respiratory therapy including short of breath when resting, with activity, or when lying flat. The policy stated an area to address on the comprehensive care plan is dialysis including frequency, location, contact information, site monitoring/care, identifying/preventing infections, and complications, and what to do in an event of emergency or weather-related delays in care. The facility policy titled "Dialysis Care Plan and Treatment Sheet" policy and procedure effective 2/2019 stated the dialysis care plan should include the name of the dialysis location with the phone number, the days the resident is scheduled to receive dialysis, monitoring for complications following dialysis including hypotension, febrile reaction, bleeding, and infection, emergency measures, fluid restrictions including measured intake and for nursing to monitor for compliance or non-compliance, precautions to include, monitoring the vascular access including to check bruit and thrill, checking for redness, edema, and drainage position, monitoring weight and vital signs, send a meal/snack to dialysis, shunt dressings to be changed, what to do if a resident refuses to go to dialysis, and to monitor emotional status and provide psychosocial interventions as indicated.	2 565		

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2 565	Continued From page 10 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.	2 565		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication;	2 625		8/11/24

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2 625	Continued From page 11 H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure a medical record was accurately document vital signs and assessments for one of one resident (R1) reviewed for medical records. R1's treatment administration record (TAR) indicated R1 was to have a pre-and-post dialysis assessment done three days a week and all but three of those assessments were not completed. R1's vital signs were documented while he was not in the facility. Findings include: R1's medical record indicated R1 was admitted to the facility on 5/28/24 with a primary diagnosis of sepsis. R1's additional diagnoses included	2 625	1. In continuing compliance with F698-Dialysis, Woodlyn Heights Senior Living corrected the deficiency by reviewing all residents on dialysis ensure pre/post dialysis assessment is in on treatment administration record to remind licensed nurses to complete assessment by the Director of Nursing by 8/7/2024. R1 was discharged from the facility on 7/8/24. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated on completion of pre/post dialysis assessment and ensuring treatment administration record is not signed off until assessment is completed	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 12 bronchiectasis, dysphagia, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD). R1 was discharged from the facility on 7/10/24. R1's hospital discharge summary dated 5/28/24 indicated R1 was inpatient from 3/22/24 to 5/28/24. R1's admitting diagnosis was respiratory failure with hypoxia, including acute kidney injury, delirium, pneumonia, two-time renal transplant, hypertensive heart and chronic kidney disease with heart failure and unspecified stage chronic kidney disease, hypothyroidism, anemia, pacemaker cardiac status, immunodeficiency due to drugs, congestive heart failure, urinary retention, schizoaffective disorder (chronic), and infection and inflammatory reaction due to cystostomy catheter. R1 was diagnosed with severe sepsis from Escherichia coli (E. coli) and Enterobacter cystitis in the setting of suprapubic catheter with possible component of community-acquired pneumonia. R1's hospital course was complicated by recurrent episodes of transient hypoxia thought to be due to either mucus plugging or recurrent aspiration events. R1 continued to have these episodes despite transition to jejunal feeds and while taking nothing by mouth (NPO). R1 was on a modified diet for dysphagia and had scheduled dialysis. R1's heath was improving, and he was free of communicable disease. It was determined R1 required skilled nursing care. Respiratory therapy recommendations included DuoNebs followed by Hypertonic saline nebulizers three times a day done simultaneously with chest vest therapy (Also called chest physiotherapy. Chest physiotherapy is a treatment used to improve breathing by the indirect removal of mucus from the breathing passages.) The facility was to ensure nebulizer was cleaned daily.	2 625	by the Director of Nursing by 8/7/2024. The Director of Nursing and/or designee will audit 3 residents for pre/post dialysis assessment completion weekly x 12 weeks and then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process. 4. The Director of Nursing is responsible for this area of compliance.	

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	00829	A. BUILDING: _____ B. WING _____	C 07/17/2024

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2 625	Continued From page 13 R1's medication administration record (MAR) dated 5/29/24 indicated R1 was to received Ipratropium-Albuterol Inhalation Solution at three milliliters (mL) inhaled orally via nebulizer three times a day for shortness of breath. The entry indicated staff was to listen and record R1's lung sounds three times a day before and after the Ipratropium-Albuterol Inhalation Solution treatment. Staff marked that the lungs were clear everyday and every time the Ipratropium-Albuterol Inhalation Solution was given except for when R1 was hospitalized from 6/27/24 to 7/1/24 and from 7/8/24 to 7/9/24. The order was discontinued on 7/9/24 due to R1 being discharged. R1's treatment administration record (TAR) dated 5/29/24 indicated nursing was to complete a pre-and-post dialysis assessment before dialysis and on return from dialysis on Mondays, Wednesdays, and Fridays. The pre-dialysis assessment included vital signs, level of consciousness, if the resident had experienced any muscle cramping, itching, discomfort, or pain, and if there was a thrill and bruit noted. The post-dialysis assessment included vital signs, if the resident had experienced any dizziness, nausea, vomiting, fatigue, chills, shaking, muscle weakness, skin flushing, itching, or diarrhea, if there was a thrill and bruit noted, and a place to enter access site notes. On 7/8/24, the TAR signed by registered nurse (RN)-A stating the pre-and-post dialysis assessment was completed but an assessment was not completed. The TAR was signed off that the assessment was completed every Monday, Wednesday, and Friday except for when R1 was in the hospital from 6/27/24 through 7/1/24 and from 7/8/24 to 7/10/24. The pre-and-post dialysis assessment	2 625		

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2 625	Continued From page 14 had only been completed on 6/10/24, 6/17/24, and 6/19/24 during his admission. R1's hospital records indicated R1 was admitted to the hospital from 6/27/24 to 7/1/24 after a witnessed fall. R1's admitting diagnosis was a fall including closed fracture of proximal end of right ulna, laceration of left lower extremity, hypomagnesemia, hypophosphatemia, acute hypokalemia, cardiac pacemaker, dysphagia, end stage renal disease, closed fracture of right olecranon process, hypotension, malnutrition, hypovolemia, and anemia. Assessments indicated R1 had crackle/coarse and expiratory wheezes in all lobes of R1's lungs. During R1's hospitalization, respiratory therapy administered R1's nebulizer and performed chest physiotherapy. The discharge exam on 7/1/24 indicated R1 had coarse bilateral lung sounds in all lobes of the lungs. It was noted R1 should continue with his vest therapy and saline nebulizers and DuoNebs as ordered. R1's Admission/Readmission and Care Plan Nursing Assessment dated 7/3/24 indicated R1 was not on a nebulizer, R1 did not have oxygen needs, and R1 had "normal" lung sounds. R1's progress note written by the nurse manager (NM) on 7/3/24 at 4:58 p.m. indicated R1 did not have any respiratory devices. R1's vital signs documented on 7/8/24 at 2:01 p.m. indicated R1's oxygen was ninety-six percent while R1 was on oxygen via nasal cannula, blood pressure was one hundred twenty over seventy-four mmHg while lying and blood pressure was taken on right arm, pain score was five, pulse was seventy beats per minute, and lungs were clear. R1's temperature and	2 625		

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2 625	Continued From page 15 respirations were not taken at this time. R1's hospital discharge record dated 7/8/24 indicated R1 was transferred from the dialysis clinic to the hospital due at 12:52 p.m. due to hypotension and shortness of breath. Hospital records indicated R1 was admitted to the hospital due to acute respiratory failure with hypoxia, COPD exacerbation, and pneumonia of left lower lobe due to infectious organism. The hospital records indicated R1 had bilateral significant wheezing, crackles, and had coarse sounds in his lungs that had been "brewing" for a few days. Hospital records indicated R1 had severe sepsis from community acquired pneumonia, COPD, and aspiration pneumonitis. Hospital records indicated R1 was transferred to the intensive care unit (ICU). Hospital records indicated R1 continued to have increased oxygen requirements, was altered, unresponsive to questions, and unable to tolerate secretions. Hospital records indicated R1 died on 7/10/24 due to severe sepsis with shock, pneumonia of left lower lobe due to infectious organism, and acute hypoxic respiratory failure. ' R1's vital signs documentation indicated R1's vital signs were taking on 7/8/24 at 2:01 p.m. R1's blood pressure was one hundred twenty over seventy-four, oxygen was ninety-six percent on oxygen via nasal cannula, pain was scored at five, and pulse was seventy beats per minute. R1's temperature and respirations were not documented. During an interview with nursing assistant (NA)-B on 7/15/24 at 12:32 p.m., NA-B stated R1 did not have respiratory problems during his admission at the facility.	2 625		

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2 625	Continued From page 16 During an interview with registered nurse (RN)-A on 7/15/24 at 12:49 p.m., RN-A stated he was R1's nurse on 7/8/24 and R1 had gone to dialysis that morning. Then on 7/16/24 at 2:48 p.m., RN-A stated he believed he had taken R1's vital signs on 7/8/24 but could not remember what the vital sign readings were. RN-A stated from what he remembered, R1 had been a little more tired than his baseline, but that his appearance was "nothing out of the ordinary". RN-A stated he does not remember R1's lungs being wheezy on 7/8/24. On 7/16/24 at 3:00 p.m., RN-A stated he did not see any concerns with R1 leaving for dialysis on 7/8/24. During an interview with the NM on 7/15/24 at 12:59 p.m., the NM stated R1's dialysis center called him and left a voicemail from the DN stating R1 was having shortness of breath and the dialysis center sent R1 to the hospital and directed him to follow up with the hospital. The NM stated R1 never complained of shortness of breath to him. The NM stated R1 was on continuous oxygen, and he was compliant with his oxygen use. During an interview with R1's guardian on 7/15/24 at 1:09 p.m., the guardian stated R1 had "issues" with his lungs where he would not cough up his mucous. During an interview with the dialysis nurse (DN) on 7/16/24 at 9:13 a.m. indicated R1 came to the dialysis center on 7/8/24 with labored breathing. DN stated she sent R1 to the emergency department via ambulance due to his labored breathing. It is unknown if the dialysis clinic started R1's dialysis. An interview was attempted with the dialysis	2 625		

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2 625	Continued From page 17 center on 7/16/24 at 2:31 p.m., 3:17 p.m., 7/17/24 at 9:20 a.m., 10:07 a.m., and 3:35 p.m., but the phone kept ringing and was unable to leave a voicemail. During an interview with NA-C on 7/16/24 at 3:06 p.m., NA-C stated she did not remember R1 wheezing on 7/8/24. NA-C stated he looked very tired on 7/8/24. NA-C stated she did not remember what R1's appearance looked on 7/8/24 because she was not focused on R1's appearance. During an interview with the DON on 7/16/24 at 3:37 p.m., the DON stated the facility assessed R1's lung and respiratory status on 7/8/24 and his lungs were clear. During an interview with licensed practical nurse (LPN)-A on 7/17/24 at 2:15 p.m., LPN-A stated she worked with R1 on 7/8/24 but could not tell the writer what R1's condition was that day. LPN-A stated she did not know R1's baseline due to her being newly employed by the facility. LPN-A stated she did not think she had any concerns with R1 on 7/8/24. LPN-A stated if she did have concerns with R1 on 7/8/24 she would have called and reported it to the physician and she does not recall having to contact the physician. During an interview with the administrator on 7/17/24 at 4:09 p.m., the administrator stated it is his expectation that orders are followed exactly how they are written in a resident's chart. 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	2 625		

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2 625	Continued From page 18 ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 625		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to monitor and assess the hydration status for one of one resident (R1) reviewed for hydration. R1 had an order for tube feedings with direction to adjust the free water flushes pending hydration status one time a day and facility staff were not monitoring or assessing R1's hydration status. Findings include: R1's medical record printed on 7/15/24 indicated R1 was admitted to the facility on 5/28/24 due to sepsis. R1's additional diagnoses included hypokalemia, moderate protein-calorie malnutrition, bronchiectasis, dysphagic, chronic obstructive pulmonary disease (COPD), gout, and lymphedema. R1's hospital discharge papers dated 5/22/24 indicated R1 had a gastrostomy-jejunostomy placed on 5/18/24. The record indicated R1 was on tube feedings with an oral diet. The record indicated R1 was on a Novasource Renal diet	2 940	1. In continuing compliance with F692-Nutrition/Hydration Status Maintenance, Woodlyn Heights Senior Living corrected the deficiency by having the Dietician review all residents receiving tube feedings for appropriate hydration status. All residents receiving tube feedings had hydration monitoring added to their treatment administration record on 8/9/2024. R1 was discharged from facility on 7/8/24. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated on hydration status monitoring and physician notification by the Director of Nursing by 8/7/2024. The Director of Nursing and/or designee will audit all tube fed residents for proper hydration monitoring weekly x 12 weeks and then randomly to ensure continued compliance. 3. As part of Woodlyn Heights Senior Living's ongoing commitment to quality	8/11/24

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2 940	Continued From page 19 administered at one hundred twenty milliliters (mL) per hour for nine hours. The record indicated R1 was to receive thirty mL before and after each feeding. The record indicated R1's estimated calorie needs were one thousand twenty to two thousand ninety per day. R1's admission record indicated R1 was not on fluid restrictions but was on moderately thick liquids. R1's treatment administration record (TAR) dated 7/2/24 indicated R1 was to receive tube feeding for Novasource Renal at one hundred twenty mL per hour for nine hours a day via percutaneous endoscopic gastrostomy (PEG)- J tube with thirty milliliters (mL) free water flushes every six hours via both G and J ports. The TAR indicated to adjust the free water flushes pending hydration status one time a day. The TAR indicated this was discontinued on 7/9/24. R1's progress note dated 7/2/24 written by the dietitian indicated R1 received Novasource one hundred twenty mL per hour for nine hours overnight and if not tolerated to reduce to ninety mL per hour over twelve hours over night but that nursing had reported tolerating at one hundred twenty mL per hour at that time. The progress note indicated water flushes with thirty mL of water four times a day. The progress note indicated to adjust free water flushes pending hydration status. The progress note indicated R1 was to receive nutrisource fiber oral packet directed at one packet via G-tube three times a day for constipation with flush tube with fifteen mL water before, mixing the nutrisource fiber oral packet with sixty to one hundred twenty mL water until dissolved, then flushing the tube with thirty to sixty mL of water after. R1's hospital records from 7/8/24 indicated when	2 940	assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process. 4. The Director of Nursing is responsible for this area of compliance.	

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2 940	Continued From page 20 R1 was seen by the provider in the emergency department, R1's mucous membranes were dry and was unable to tolerate secretions. The hospital records indicated R1 would require aggressive fluid resuscitation. During an interview with R1's guardian on 7/15/24 at 1:55 p.m., the guardian stated she visited R1 at the dialysis center on 7/8/24 and the dialysis nurse (DN) had called an ambulance because R1 was so dehydrated they could not dialyze him. The guardian stated R1 was partially responsive. The guardian stated DN called for an ambulance and R1 was sent to the hospital. During an interview with nursing assistant (NA)-C on 7/16/24 at 3:06 p.m., NA-C stated she had fed R1 around 8:00 a.m. on 7/8/24. NA-C stated R1 ate about 5% of his food and had about two hundred forty mL. NA-C stated about ten minutes after she fed R1, R1 had vomited. During an interview with the director of nursing (DON) on 7/16/24 at 3:37 p.m., the DON stated she hadn't personally assessed or seen R1 dehydrated. The DON stated the dietitian, and the facility provider will determine the need for an increase or decrease in the amount of free water flushes were given to R1. The DON stated the nursing staff would be monitoring R1's fluid intake. The DON stated the fluid intake documentation in R1's tasks only included fluids R1 drank orally, and staff would document the free water flushes on the TAR and MAR. During an interview with the dietitian on 7/16/24 at 4:06 p.m., the dietitian stated she would be responsible for tracking R1's nutritional needs, including his fluid intake. The dietitian stated she was responsible for determining R1's hydration	2 940		

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2 940	Continued From page 21 status. The dietitian stated she had thought R1 was meeting his nutritional needs. The dietitian stated she would adjust the free fluid flushes if she heard from the nursing staff stating he may have needed an adjustment. The dietitian stated R1 had not presented to her with dehydration. The dietitian stated she would chart on feeding tube nutritional values monthly. During an interview with the DON on 7/17/24 at 2:26 p.m., the DON stated the interdisciplinary team met with the dietitian and discussed that R1 was not taking any fluids or foods orally and the dietitian looked at R1's current "situation" and deemed R1 was getting sufficient calories. During an interview with the administration on 7/17/24 at 4:09 p.m., the administrator stated he would expect when it came to hydration status, that the staff would do a care conference with R1 and his family and note any significant changes. The administrator stated he would expect that hydration status would be monitored daily. A policy on assessing hydration status and needs were requested and none was provided. 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.	2 940		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance	21695		8/11/24

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21695	Continued From page 22 Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide a homelike environment to two out of two residents (R2, R3) reviewed for environment. R4 had been playing his music loudly and R2 and R3 had complaints of not being able to hear their music or their televisions. Findings Include: During an observation in the 600 hallway on 7/15/24 at 11:01 a.m., R4 had his door to his room open and loud explicit music playing. This explicit music could be heard from the front entrance of the facility as well as in the other hallways. During an observation in the 600 hallway on 7/15/24 at 12:28 p.m., R4 had his door to his room open and loud music playing. This music could be heard from the front entrance of the facility as well as in the other hallways. R2's medical records printed on 7/16/24 indicated R2 was admitted to the facility on 4/12/23 with a primary diagnosis of cerebral palsy. R2's additional diagnoses included polyneuropathy, major depressive disorder, and mild intellectual disabilities.	21695	1. In continuing compliance with F584-Safe/Clean/Comfortable/Homelike Environment, Woodlyn Heights Senior Living corrected the deficiency by instructing R4 not to play music loudly with door open. R4 has a personal pair of headphones and was encouraged to use them. The facility interviewed R2, R3 and all like residents to ensure there were no other complaints about loud music/loud televisions. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on encouraging residents who play music or television loudly to turn music/television down to a reasonably level, shut their room door, or offer headphones for better listening and to ensure that they bring resident complaints of loud music or television to their supervisor by the Director of Nursing by 8/7/2024. The Director of Nursing and/or designee will audit R4 and all other residents for loud music or television 2x/week x 8 weeks, weekly x 4 weeks and then randomly to ensure continued compliance.	

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21695	Continued From page 23 R2's brief interview for mental status (BIMS) assessment dated 12/19/23 indicated R2 had a score of 15, which indicated R2 was cognitively intact. R3's medical records printed on 7/16/24 indicated R3 was admitted to the facility on 8/2/23 with a primary diagnosis of systemic lupus erythematosus. R3's additional diagnoses included polyneuropathy, generalized anxiety disorder, major depressive disorder, and insomnia. R3's BIMS assessment dated 11/13/23 indicated R3 had a score of 15, which indicated R3 was cognitively intact. R4's medical records printed on 7/16/24 indicated R4 was admitted to the facility on 1/29/24 with a primary diagnosis of orthopedic aftercare following a joint replacement or spinal surgery. R4's additional diagnoses included major depressive disorder, anxiety disorder, personality disorder, and dysthymic disorder. R4's diagnoses did not indicate R4 had hearing impairment. R4's minimum data set (MDS) dated 5/14/24 indicated R4 had a BIMS score of 14, which indicated R4 was cognitively intact. The MDS indicated R4 had adequate hearing and no hearing aides. During an interview with R2 on 7/15/24 at 12:31 p.m., R2 stated R4 had been playing his music very loud for a few days and it had been bothering her. R2 stated she told her nurse about her concerns but was unsure if staff investigated her concerns. During an interview with R3 on 7/15/24 at 12:41	21695	3. As part of Woodlyn Heights Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process. 4. The Director of Nursing is responsible for this area of compliance.	

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 07/17/2024

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21695	Continued From page 24 p.m., R3 stated R4 started playing his music very loudly last week. R3 stated the music was bothering her as she could not hear her television very well when he was playing his music loud. During an interview with R4 on 7/15/24 at 12:55 p.m., R4 stated he had just started playing his music very loud with the door open "maybe in the last two weeks". R4 stated he had been playing his music loud because other residents were playing their music and television loud. R4 stated he was playing his music loud to anger the other residents who were playing their music and television loud. R4 stated he usually listened to his music on his headphones, but "since he paid to live there, he could play his music when he wanted and how loud he wanted". During an interview with the director of nursing (DON) on 7/15/24 at 3:44 p.m., the DON stated the facility creates a homelike environment by honoring the resident's wishes, cleanliness, providing a well-lite facility, ensuring the facility was free of accidents and hazards, and by creating an odor-free environment. The DON stated residents could have their music on in their rooms at a level that did not disturb other residents. The DON stated if she had heard concerns about music or noises being too loud, that she would approach the resident and ask them to turn their music or television down. The DON stated she had not heard of any complaints from residents about loud music or television. During my interview with the administrator on 7/17/24 at 4:09 p.m., the administrator stated if a resident had a concern about music or television distractions, himself, the DON, and the social worker would have a conversation with the other resident to see if they could find an alternative	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21695	Continued From page 25 solution to ensure everyone's needs were being met. A policy for a homelike environment was requested and none was 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.	21695		