Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 8, 2025

Administrator
WOODLAKE HEALTHCARE AND REHABILITATION CENTER
8000 BASS LAKE ROAD
CRYSTAL, MN 55428

RE: CCN: 245518
Cycle Start Date: September 12, 2025

Dear Administrator:

On November 28, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 1, 2025

Administrator
Woodlake Healthcare and Rehabilitation Center
8000 Bass Lake Road
Crystal, MN 55428

RE: CCN:245518

Cycle Start Date: September 12, 2025

Dear Administrator:

On September 12, 2025, a survey was completed at your facility by the Minnesota Departments 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 12, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 12, 2026 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question

cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered

October 1, 2025

Administrator
Woodlake Healthcare and Rehabilitation Center
8000 Bass Lake Road
Crystal, MN 55428

Re: Event ID: 1D6962-H1

Dear Administrator:

The above facility survey was completed on September 12, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAKE HEALTHCARE AND REHABILITATION CENTER	**8000 BASS LAKE ROAD , CRYSTAL, Minnesota, 55428**

(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
20000	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: On9/11/25 through 9/12/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaint was reviewed during the survey. H55183061C (2600773). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of	20000		10/21/2025

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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20000	Continued from page 1 the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245518**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/12/2025**

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WOODLAKE HEALTHCARE AND REHABILITATION CENTER	**8000 BASS LAKE ROAD , CRYSTAL, Minnesota, 55428**

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F0000	INITIAL COMMENTS On 9/11/25 through 9/12/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed. H55183061C (2600773) with a deficiency cited at F921. As a result of the survey a deficiency was cited at F558. 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.	F0000		10/21/2025
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure reasonable accommodation of resident needs and preferences upon admission to the facility for 2 of 3 residents (R1, R3) reviewed who reported concerns related to accommodation of needs upon admission to the facility. Findings include:	F0558	Residents R1 and R3 have since discharged from the facility. The community will conduct interviews for all new admissions in the last 15 days, who still reside in the community, to ask them if there are unresolved concerns from their admission. Community leadership team has reviewed the admission notification system that includes an end of day email outlining projected admissions for the next day/upcoming weekend and clinical notification template that is sent with each confirmed admission. Clinical notification template includes information such as hospital referral, summary of mobility, therapy, cognition, estimated arrival time, etc. System was found adequate for communication.	10/21/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245518	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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WOODLAKE HEALTHCARE AND REHABILITATION CENTER	**8000 BASS LAKE ROAD , CRYSTAL, Minnesota, 55428**

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F0558 SS = D	Continued from page 1 R3's Admission Record indicated admitted to the facility on 9/7/25 at 12:45 p.m. Diagnosis included fractures of left fibula and tibia (the two bones of the lower leg), pain in left wrist and left leg, fracture of left radius (one of two bones in your forearm), unsteadiness and dependence on other enabling machines and devices. R3's Interagency Transfer Orders dated 9/4/25, included oxyCodone 5 milligrams (mg). Give 5-10 mg every four hours as needed for pain. The orders indicated R3 had restricted weight bearing and indicated non-weight bearing on left leg and left arm, okayed for a platform walker at the left elbow. R3's Medication Administration Record (MAR) dated 9/1/25 through 9/30/25, indicated the following order: oxyCODONE HCl (hydrochloride) Oral Tablet 5 MG. Give two tablets by mouth every four hours as needed for pain rated 6-10 out of 10. The MAR indicated R3 received her first dose of oxyCodone at 7:45 p.m. on 9/7/25, for pain rated 10 out of 10, seven hours after she admitted to the facility. R3's Admission Assessment dated 9/7/25, indicated she admitted from the hospital via medical transport. The assessment indicated R3's lower left extremity was in a cast, ACE wrap. Left lower arm in cast, ACE wrap. Foley catheter in use. The assessment indicated R3 was chairfast with ability to walk severely limited or non-existent. Could not bear own weight and/or must be assisted into chair or wheelchair. Able to make frequent though slight changes in body or extremity position independently. The assessment identified frequent severe pain in the last five days that interfered with day-to-day activities. R3's care plan dated 9/7/25, identified the use of an indwelling catheter and indicated pain. The care plan directed staff to monitor for non-verbal pain indicators or change in behavior related to pain such as grimacing, change in ability to perform activities of daily living (ADL)'s and directed staff to offer nonpharmacologic interventions such as heat/cold, massage and distraction. The care plan further identified and ADL and mobility deficit and indicated she transferred using a platform walker. R3's Progress Notes indicated the following: -9/7/25 at 3:38 p.m., R3 arrived on the unit at 12:45 p.m. R3 was alert and oriented and able to make needs known. R3 was oriented to room, call lights and	F0558	Continued from page 1 A room readiness meeting was held on 9/8 with a welcome booklet being added to residents' room for increased communication on 9/11. Licensed Nurses, NARS and therapy staff will be educated on admission expectations on how to provide appropriate equipment. Licensed nurses will be re-educated on how to determine transfer status and the expectation for obtaining emergency medications. DON or designee will audit all weekend admissions weekly x 4 weeks to ensure transfer status, pain, and equipment is addressed. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.	

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F0558 SS = D	Continued from page 2 questions were answered as best as writer could. -9/8/25 at 5:55 a.m., R3 reported severe pain in left arm and leg, as needed oxyCodone was given around the clock to manage pain. R3 had approximately three hours of sleep the previous night. -9/9/25, Social services met with R3 and family member (FM)-B and discussed options for transitional care unit transfer as well as going to the hospital. R3 decided to go to the hospital. 9/9/25, R3 left the facility via ambulance. FM-B spoke with writer and nurse manager, verbalized wanting to go to the emergency department and not come back to the facility. During interview on 9/11/25 at 3:12 p.m., family member (FM)-B stated R3 went through "48 hours of hell", when R3 admitted to the facility on Sunday at noon and had not received pain medication prior to discharge from the hospital, got to her new room at the facility where she was transferred into bed by the Medivan driver, himself and a staff person. FM-B said there were no mobility devices in the room and staff said someone from physical therapy would be performing an assessment on Monday but until then, R3 would have to remain in bed. FM-B said a commode was brought into her room but there was no way to get R3 onto to it because there were no devices. FM-B added he stayed for several hours and left for a couple hours and R3 called and asked him to come back. He stated they learned she was not going to get any pain medication because the pharmacy only delivered once a day on the weekends. He said R3 was at "max pain", had not received pain medication since the morning and finally received pain medication again at 8:00 p.m. and said all they had offered prior was Tylenol. FM-B said R3 had been beside herself in pain. FM-B said the next morning he talked to social services and reported what had happened. He said a therapy assessment was not completed until 4:00 p.m. on Monday and therapy had at least brought a recliner, walker and a grab bar. FM-B said the second night was no better than the first and said R3 asked for a suppository and was assisted onto the commode and because the suppository was not effective a staff member forcibly put an adult diaper on R3 and put her back to bed. Then, around 10:00 p.m., two staff came into the room and turned on the light talking about how they were looking for something which woke R3 up. FM-B added, "We had to get her out of there." FM-A said they told the social worker they were going to leave and were not coming back.	F0558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245518**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/12/2025**

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F0558 SS = D	Continued from page 3 During interview on 9/12/55 at 8:13 a.m., licensed practical nurse (LPN)-A stated therapy worked on the weekends sometimes but said most of the time she did not see them. LPN-A stated technically when they had a new admission, until therapy assessed them, she could not give them a walker. LPN-A said sometimes people were a little upset when they come in and said it could be that someone could not get out of bed until therapy came. LPN-A stated if a resident came and needed a pain medication they could get it from the emergency kit. During interview on 9/12/25 at 8:35 a.m., the therapy director stated the weekend coverage was 50/50. The therapy director said if equipment was needed on a weekend nursing was supposed to ensure it was available. During interview on 9/12/25 at 8:42 a.m., nursing assistant (NA)- A stated when someone admitted to the facility the admission orders directed diet, transfer status, etcetera. NA-A said sometimes they could ask the paramedics how someone transferred when they arrived. NA-A said therapy had to do an assessment and said if a resident needed equipment therapy had to tell them that, for instance if they had a special walker, "we don't have that." NA-A said they tell residents they had to stay in bed until therapy assessed them, and they would use a bed pan until the needed equipment arrived. NA-A stated, if someone came on a weekend they had to stay in bed until therapy could evaluate. During interview on 9/12/25 at approximately 9:00 a.m., social service designee (SSD)-B stated there was a grievance filed and said R3 had waited a while to get pain medications and also had an incident in which a nursing assistant (NA) had spilled a catheter. SSD-B said the medications was "a big one." During interview on 9/12/25 at 11:22 a.m., the director of nursing (DON) stated R3 came in with pain on a Sunday and said the nurse had an order for pain medication and faxed it to the pharmacy. The DON said by evening, staff called the pharmacy and got the okay to get a dose from the emergency kit. The DON said the nurses could call the pharmacy anytime to request a medication from the emergency kit. The DON said R3's main concern was pain medication and said she talked about not having a grab bar for the bed. The DON said they preferred to wait for therapy to do an assessment before providing devices. During interview on 9/12/25 at 10:16 a.m., R3 stated	F0558		

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F0558 SS = D	Continued from page 4 she never wanted to go back to "one of those places," referring to the facility. R3 said when she got to the facility, she had no ability to put weight on her left arm or leg and said once she got into the bed she had no way to shift her weight or get any leverage and said she felt very "trapped." R3 said when she asked about a walker she was told physical therapy would bring one but not until the next day. R3 said she did not think the facility was equipped to care for her when she admitted, had no wheelchair she could get into and no pain medications until 7:45 p.m., even though she had asked for them. She said the nurse told her they would not have medications until later in the day and the pain just kept getting worse and worse. R3 said there was a lack of preparation and said the staff had no knowledge of how to get her out of bed. She said she could not get staff to help and could not do it herself. R3 said the overnight staff were not helpful R1's Admission Record indicated he admitted to the facility on 8/21/25. Diagnosis included surgery of digestive system, chronic pain, and weakness. R1's Admission Assessment dated 8/21/25, indicated he admitted to the facility on 8/21/25. The assessment indicated R1 was alert and oriented, had a colostomy and was continent of bladder. The assessment indicated R1 walked occasionally but for very short distances and spent the majority of each shift in bed or chair. R1's care plan dated 8/21/25, identified intact cognition and indicated R1 had a new colostomy and directed staff to check device each shift, and ass needed for appropriate fit, leakage and need for emptying. The care plan identified a self-care deficit and indicated he required assistance from staff for grooming, toileting, ambulation and wheelchair mobility. During interview on 9/11/25 at 12:25 p.m., FM-A stated R1 had been at the facility in the past and had received great care but since his current admission had not received good care. FM-A said he spent approximately eight hours a day at the facility during R1's stay. FM-A stated the first night R1 was at the facility, he (FM)-A got to the facility after 7:00 p.m. and the door was locked and no one would answer the phone to let him in. When he finally got in, R1's call light was on, and he was lying in a puddle of urine and waited an hour for someone to help him. FM-A said, "it was so bad," and said he couldn't find anyone to help R1. FM-A said one of the nights, he waited two hours for someone to come and change R1's colostomy bag so he	F0558		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0558 SS = D	Continued from page 5 started to do it himself. FM-A said when a nurse finally came in, she asked how to change the bag.	F0558		
F0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to maintain an environment that was clean and free from odors for 3 of 3 residents (R1, R2, R3) reviewed for environmental concerns. Findings include: During observation of the two-east unit on 9/11/25 at 10:50 a.m., a musty odor was observed outside room 252. During observation on the east unit on 9/12/25 at 8:23 a.m., the hallway outside of room 273 smelled of urine. No trash or linen carts were in the vicinity. R1's Admission Record indicated he admitted to the facility on 8/21/25. Diagnosis included Surgery of digestive system, chronic pain, and weakness. During interview on 9/11/25 at 10:39 a.m., family member (FM)-A stated "it smelled like death" in his dad bathroom when he was at the facility even after they had cleaned it. R2's Admission Record indicated she admitted to the facility 9/3/25 and resided on the two- east unit of the facility. Diagnosis included muscle weakness, DMII, hypertension and history of falls. R2's Brief interview for mental status (BIMS) dated 9/4/25, indicated her short and long terms memory was intact. During interview on 9/11/25 at 11:47 a.m., R2 stated she had been at the facility for about two weeks. R2 stated the facility has had the same carpet for 10 years and said, "they dumped me in this shit hole." R2 said the carpet is stained and musty and said the housekeepers did not vacuum, just swept the carpet. R2 pulled out a bottle labeled fungicide she had ordered	F0921	R1, R2, and R3, have all since discharged. R3's room was addressed immediately upon notification of concern. R2 room was addressed by EVS director on 9/12/2025. R2's room was extracted on 9/12/2025, R2 was moved to another room on 9/18/2025 per residents preference. The facility maintains a safe/functional/sanitary/comfortable environment through daily housekeeping services and consistent rounding by leadership team members. The community utilizes TELS for work orders including carpet extraction. The facility will conduct an environmental round on the identified unit to create a worklist of identify odors, stains, or unclean areas that has the ability to impact other residents. The Housekeeping director will continue to schedule deep cleaning and extractions as needed. The housekeeping department will be re-educated on this process. The leadership team will be re-educated that TELS can be utilized for work orders that include carpet extractions. The administrator, or designee will conduct weekly environmental audits of 10 rooms x 4 weeks to ensure rooms are free of odor and sanitary. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.	10/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245518	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAKE HEALTHCARE AND REHABILITATION CENTER	8000 BASS LAKE ROAD , CRYSTAL, Minnesota, 55428

(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
F0921 SS = E	Continued from page 6 and said the carpet smelled better since she started using it and said she planned to spray the recliner they brought up from the basement because it stunk. R3's Admission Record indicated she resided on the two-east unit of the facility. Diagnosis included fractures of left fibula and tibia (the two bones of the lower leg), pain in left wrist and left leg, fracture of left radius (one of two bones in your forearm), unsteadiness and dependence on other enabling machines and devices. During interview on 9/11/25 at 3:12 p.m., family member (FM)-B stated when R3 got to the facility, the first thing he smelled when they got to her unit was urine. FM-B said R3 had a catheter and the first night a staff member came to empty it and did not place the cap on it and the catheter was leaking urine all over the floor. FM-B said the second time the staff member emptied the catheter bag, she spilled urine on the floor then rubbed the urine into the carpet with a brown paper towel. A facility grievance form dated 8/4/25, filed by FM-C, indicated "Residents room is a mess, not enough garbage cans, floor dirty." During interview on 9/12/25 at 10:01 a.m., social service designee (SSD)-A said she was aware of the concerns reported by R3. SSD- A said the concerns included the urine on the carpet, no recliner in the room and some other things. SSD-A said because of the scenarios, R3 did not think the facility was welcoming or clean. During interview on 9/12/25 at 10:52 a.m. the environmental services director (ESD) said typically if she was made aware of a concern and spoke with the resident and/or family and said if training was needed, they would do that. The ESD stated the facility currently did not have a floor technician and said she would like to have the hallways cleaned at least once per week but said they were currently "stretched thin."	F0921		