Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 15, 2026

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

RE: CCN: 245235
Cycle Start Date: August 13, 2026

Dear Administrator:

On August 25, 2026, we informed you that we may impose enforcement remedies.

On August 26, 2026, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS 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 September 30, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 30, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 30, 2026.

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 $13,343, 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 September 30, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, WOODBURY HEALTH CARE CENTER will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 30, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 13, 2027 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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 tamika.brown@cms.hhs.gov.

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,



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
September 15, 2026

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

Re: State Nursing Home Licensing Orders
Event ID: 342BFF-H1

Dear Administrator:

The above facility survey was completed on August 26, 2026 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 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

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October 12, 2026

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

RE: CCN: 245235
Cycle Start Date: August 13, 2026

Dear Administrator:

On September 15, 2026, we notified you a remedy was imposed. On October 8, 2026 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 September 30, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 30, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of [Custom Date Prompt (Words)(Date of letter imposing remedies)], 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 September 30, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 30, 2026, 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.

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

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October 12, 2026

Administrator
WOODBURY HEALTH CARE CENTER
7012 LAKE ROAD
WOODBURY, MN 55125

Re: Reinspection Results
Event ID: 31CA5C-H2 and 342BFF-H2

Dear Administrator:

On October 1, 2026 and October 8, 2026 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 August 13, 2026 and August 26, 2026. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD , WOODBURY, Minnesota, 55125

(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
F0000	INITIAL COMMENTS On 8/24/26, 8/25/26 and 8/26/26, 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 complaint was reviewed: H52353864C (3171398) with a deficiency issued at F580, F684, F686 and F692. 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		09/15/2026
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F0686	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. F686 Description of Correction: 1. Corrective Action for Identified Resident:	09/24/2026

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: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

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F0686 SS = G	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, evaluate, and implement individualized interventions to prevent/treat pressure ulcers, including timely physician notification for 1 of 3 residents (R1) reviewed for pressure ulcers. The facility's failures resulted in harm when R1's moisture associated skin damage deteriorated to a stage 3 pressure ulcer. Findings include: Findings include: Moisture-Associated Skin Damage (MASD): Inflammation and erosion of the skin caused by prolonged or continuous exposure to moisture and chemical irritants, including urine, feces, sweat, or wound drainage. This exposure breaks down the skin's protective acid mantle and lipids, causing overhydration and maceration (softening and wrinkling of the tissue). Wounds are typically superficial, affecting the top layers of skin with diffuse, irregular edges, and are not classified by stages. Incontinence-associated dermatitis (IAD) is the most common form. While MASD involves partial-thickness skin loss, it can quickly convert to a pressure injury if underlying pressure or shearing forces are also present Stage 3 Pressure Ulcer: Full-thickness skin loss, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI (pressure ulcer/pressure injury). R1's Face sheet identified diagnoses of chronic kidney disease stage 4 (severe kidney damage where the organ can no longer filter waste properly), metabolic encephalopathy (brain dysfunction and confusion caused by severe chemical imbalances in the body), and nutritional deficiency (severe malnutrition from a lack of food and fluids). R1's admission Minimum Data Set (MDS) dated 5/19/26, identified R1 had moderate cognitive	F0686	Continued from page 1 R1 has discharged from the community . The leadership team will complete and document a retrospective review of the July 13 to July 28 medical record to review for skin changes, assessment and staging, provider notification, orders, moisture management, repositioning, nutrition, care plan, and escalation. Findings will be referred to QAPI and used in staff education. 2. Identification of Other Residents Potentially Affected: The DON or designee will review all current residents for pressure injury, moisture associated skin damage, skin alterations or other identified skin risk issues. Licensed nurses will perform a current body audit for all residents and complete provider notification, obtain treatment orders, evaluate current interventions for effectiveness and update care plans as indicated. 3. Systemic Changes: Policies related to, pressure injury prevention, and skin assessment were reviewed and are appropriate as written. Policy related to provider notification has been reviewed and updated. Basic wound and skin integrity education will be provided to all clinical staff and will include identification of residents at risk for skin breakdown, signs and symptoms of developing skin damage, proactive prevention interventions, reevaluation of intervention effectiveness, timely reporting of skin alterations to licensed nursing staff, provider notification, obtaining treatment orders, and ongoing monitoring of skin alterations. Nursing staff will complete weekly and PRN skin audits on all residents. Any new or worsening skin condition will be assessed, documented, reported to the appropriate provider, wound prevention interventions initiated as indicated and the skin concerns will be monitored through resolution. 4. Monitoring Plan: DON and/or designee will review skin audits and documentation daily Monday through Friday for new skin issues, changes in condition, discrepancies in	09/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

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F0686 SS = G	Continued from page 2 impairment and was dependent with toileting, dressing and transfers. R1 did not have behaviors including no rejection of care. Further identified R1 was at risk for pressure ulcers and had one stage 2 pressure ulcer upon admission. R1 had a pressure reducing device for bed and chair, nutrition hydration intervention to manage skin problems, pressure injury care, and application of ointments/medications other than to feet. R1’s care area assessment (CAA) dated 5/19/26, identified R1 was at an actual risk for developing pressure ulcers. The assessment identified R1 required staff assistance for bed movement, required a special mattress or seat cushion to relieve pressure, and required a regular turning schedule. The analysis concluded that the care plan would focus on pressure relief, repositioning, incontinence management, and daily skin monitoring. R1’s care plan revised 5/22/26, identified a focus of potential or actual impairment to skin integrity related to incontinence, a need for staff assistance with position changes, diabetes, and a risk of malnutrition and obesity. Interventions dated 5/15/26, directed staff to attempt to reposition R1 off the area, encourage good nutrition and hydration to promote healthier skin, and keep linens dry and wrinkle-free. The plan further directed staff to observe skin during cares, report changes to the nurse, offer toilet assistance before meals and at bedtime, and utilize pressure-relieving support surfaces in his bed and chair. An intervention dated 5/22/26 directed staff to complete a weekly skin inspection and as needed. R1’s progress note dated 6/14/26 at 2:29 p.m., identified a skin check was completed. The note showed R1's skin was warm and dry, skin color was within normal limits, and no skin issues were identified. R1’s progress note dated 6/26/2026 10:34 p.m., identified a skin check was completed. The note showed R1's skin was warm and dry, skin color was within normal limits, and no skin issues were identified. R1’s progress note dated 7/13/26 at 2:43 p.m., identified a new in-house acquired skin issue on the intergluteal cleft (the crack of the buttocks). The note identified the injury as moisture-associated skin damage (MASD) and incontinence-associated dermatitis (IAD)-(skin damage caused by prolonged exposure to urine or stool). The documentation showed that wound measurements were not	F0686	Continued from page 2 documentation, provider notification, treatment orders, and evidence of worsening conditions. Findings will be followed up timely. Audits will occur 5x weekly for 30 days. Results will be reviewed by the QAPI Committee, which will evaluate compliance and determine whether additional monitoring or interventions are indicated. Education changes, and corrective action provided as indicated. Woodbury Health Care Center will be in substantial compliance by 9.24.2026.	09/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

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F0686 SS = G	Continued from page 3 recorded during this assessment. R1’s progress note dated 7/17/26 at 9:59 p.m., identified a weekly skin check was completed. The note identified the in-house acquired skin issue on the intergluteal cleft was MASD and IAD. Review of R1’s medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the development of this in-house acquired skin injury. The documentation further failed to identify any measurements and characteristics of the wound, protective nursing interventions, or medical treatment orders put in place to manage the skin damage. R1’s progress note dated 7/24/26 at 10:57 p.m., identified a weekly skin check was completed. The note identified the in-house acquired skin issue on the intergluteal cleft had transitioned to a pressure ulcer. The note documented that the wound was stable, but measurements were not recorded because the resident was uncooperative. Furthermore, did not identify what stage the pressure ulcer was. Review of R1’s medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the development of this in-house acquired pressure ulcer. The documentation further failed to identify any measurements and characteristics of the wound, protective nursing interventions, or medical treatment orders put in place to manage the pressure injury. R1’s nutrition progress note dated 7/27/26 at 12:15 p.m., identified R1 was at high risk related to wound healing for a pressure area on the intergluteal cleft. The note identified R1 had increased nutritional needs, and the dietitian would follow up on oral supplements. The documentation showed R1's meal intakes ranged from 25 percent to 100 percent, his weight was 197 pounds, and no significant weight loss or weight gain was recorded. R1’s hospital noted dated 7/28/26 at 8:58 a.m., identified a photographic review of R1's sacrum area showing a single wound pressure injury that was identified as a stage 3 pressure ulcer. The photograph reviewed showed a raw, red, open wound bed over the sacral and gluteal region with a fluid blister, extensive deep purple tissue discoloration, surrounding skin shearing, and widespread red mottling across both buttocks. R1’s record reviewed which included Point of Care	F0686		09/24/2026

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F0686 SS = G	Continued from page 4 documentation and progress notes between 7/13/26 through 7/28/26 did not include any documentation of rejection/refusal of care behaviors. During a phone interview on 8/24/26 at 9:45 a.m., family member (FM)-A stated R1 originally entered the facility with a pressure ulcer that healed quickly, which placed him at a high risk for developing another one. FM-A stated R1 developed an ugly wound on his buttocks because staff left him lying in bed and sitting in wet briefs for long periods. FM-A stated the hospital took a picture of the pressure ulcer upon admission and noted the injury could have been prevented. During an interview on 8/25/26 at 10:57 a.m., nursing assistant (NA)-A stated she worked with R1 frequently on the day shift and checked him for wet briefs every two hours. NA-A stated R1 rarely wanted to get out of bed, and if he did, he wanted to lie back down fifteen minutes later. NA-A stated R1 would claim he was dry when he was actually wet, requiring significant encouragement to even check him, and he was always wet when changed. NA-A stated R1 developed an open area on his tailbone in the middle of July, approximately two weeks before his hospital transfer, and she reported this out-of-the-normal finding directly to the nurse on duty. During an interview on 8/25/26 at 2:23 p.m., registered nurse (RN) quality assurance director (QAD)-A, who was acting as the director of nursing (DON), verified R1 was bed-bound and dependent on staff for repositioning. QAD-A verified moisture-associated skin damage developed on R1's sacrum on 7/13/26 with no provider notification or treatment in place. QAD-A stated after R1’s pressure ulcer developed on 7/24/26, the facility had no assessment, monitoring, treatment, or provider notification in place. QAD-A confirmed there were no treatment orders or person-centered prevention interventions in place for the pressure injury. During a phone interview on 8/26/26 at 1:04 p.m., nurse practitioner (NP)-A stated she was not notified of R1's MASD on 7/13/26 or the development of pressure ulcer on 7/24/26 and confirmed that standard practice requires immediate provider notification of condition changes as well as daily skin assessments. NP-A stated the facility could have implemented standing house orders until a provider was able to look at it. NP-a further stated had been notified of the MASD, she would have	F0686		09/24/2026

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F0686 SS = G	Continued from page 5 ordered immediate treatments, including moisture barrier creams, strict turning schedules, and frequent incontinence checks to protect the skin and prevent it from breaking down into a pressure ulcer. Facility policy, Lifespark Pressure Injury Prevention Guidelines, dated 4/2026, identified it was the policy of the facility to implement evidence-based interventions to prevent avoidable pressure injuries and promote healing. The policy identified individualized interventions must address specific factors including moisture management, impaired mobility, nutritional deficits, staging, and wound characteristics. The guidelines directed staff to keep the skin clean and dry, manage incontinence by checking the resident every 2 hours, and protect the skin from excessive moisture with barrier products. The policy further identified a routine repositioning schedule of every two hours, using both side-lying and back positions when a resident was in bed and out of bed. The guidelines mandated that in the absence of prevention orders, the licensed nurse must utilize nursing judgment and notify the physician to obtain orders.	F0686		09/24/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F0580	F580 Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. Description of Correction: 1. Corrective Action for Identified Residents: R1 has discharged from the community. R3 was reviewed by nursing. The changes in condition were assessed and documented, and the appropriate provider was notified. Orders and interventions were obtained and implemented as indicated. 2. Identification of Other Residents Potentially	09/24/2026

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F0580 SS = D	Continued from page 6 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to notify the physician with change in condition who required prn medication for nausea and vomiting for 1 of 1 resident (R1) and for 1 of 1 resident (R3) who developed a non-pressure skin lesion. Findings include: R1's face sheet printed 8/26/26, identified diagnoses of chronic kidney disease stage 4 (severe kidney damage), metabolic encephalopathy (brain dysfunction causing confusion), and nutritional deficiency (severe malnutrition). R1's order summary dated 5/13/26, identified an order for sodium bicarbonate 650 mg (a medication used to balance high acid levels in the blood caused by kidney failure), two tablets twice a day. An additional order dated 6/15/26, directed staff to give ondansetron 4 mg (an anti-nausea medication used	F0580	Continued from page 6 Affected: DON or designee will review current residents for new skin alterations, repeated nausea or vomiting, declining intake, repeated PRN use for an unresolved symptom, or other significant condition changes in the preceding 14 days. All changes in condition identified in the review will be audited for timely physician consultation, resident and representative notification if required, and follow-up documentation with interventions initiated as indicated. 3. Systemic Changes: . The policy related to provider notification has been reviewed and updated. RNs and LPNs will be educated on identifying and responding to changes in condition including changes in medication regimen, including timely assessment, documentation, provider notification, obtaining orders, and follow-up. CNAs will be educated on recognizing changes from a resident's normal habits, condition, or behavior and the importance of immediately reporting changes to the licensed nurse for further assessment and monitoring. Don and/or designee will review and audit the 24-hour report including progress notes daily. Don and/or designee to elevate action items for appropriate follow up. 4. Monitoring Plan: DON and/or designee will audit the 24-hour report including progress notes 3x weekly for 3 months for appropriate provider notifications. Results of audits will be reviewed by the QAPI Committee, which will evaluate compliance and determine whether additional monitoring or interventions are indicated. Education changes, and corrective action provided as indicated. Date Corrected: Woodbury Health Care Center will be in substantial compliance by 9.24.2026.	09/24/2026

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F0580 SS = D	Continued from page 7 to prevent throwing up) every 4 hours as needed for nausea. R1’s admission Minimum Data Set (MDS) assessment dated 5/19/26, identified R1 had moderate cognitive impairment and entered the facility with one stage 2 pressure ulcer. R1’s progress note dated 6/4/26, identified R1 vomited after taking his morning medication and blamed the sodium bicarbonate tablets. An additional note at 4:47 p.m. identified R1 refused the medication until he could see his provider. The provider was notified and wanted R1 to continue the medication. R1’s nurse practitioner (NP) visit note dated 6/8/26, identified R1 reported vomiting at breakfast and lunch most days and felt it was related to the sodium bicarbonate pill. New orders were received to discontinue (stop) the morning dose of sodium bicarbonate due to vomiting, but to continue the afternoon dose. R1’s progress note dated 6/11/26 at 4:00 p.m., identified R1 refused to take his evening dose of sodium bicarbonate and stated that it made him sick and upset his stomach. R1’s progress note dated 6/22/26 at 10:14 a.m., identified ondansetron 4 milligrams (mg) was given because R1 vomited that morning. R1’s progress note dated 6/29/26 at 2:57 p.m., identified ondansetron 4 mg was given for nausea. R1’s progress note dated 6/30/26 at 1:03 a.m., identified ondansetron 4 mg was given for nausea. R1’s progress note dated 6/30/26 at 8:41 a.m., identified R1 reported feeling nauseous and received PRN (as-needed) ondansetron. The note further identified R1 was hungry but refused to eat solid foods, drinking only broth and sipping on water. R1’s progress note dated 7/1/26 at 8:36 a.m., identified ondansetron 4 mg was given for nausea. R1’s progress note dated 7/16/26 at 9:41 a.m., identified ondansetron 4 mg was given because R1 was nauseated after breakfast. R1’s progress note dated 7/24/26 at 8:11 p.m., identified ondansetron 4 mg was given for nausea. R1’s progress note dated 7/25/26 at 4:26 p.m., identified ondansetron 4 mg was given for nausea	F0580		09/24/2026

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F0580 SS = D	Continued from page 8 and vomiting his lunch. Review of R1's medical records identified that licensed nursing staff repeatedly identified ongoing nausea, vomiting, and food refusals requiring multiple administrations of anti-nausea medication throughout June and July 2026. The facility documentation failed to identify any phone calls, faxes, or notifications to the medical practitioner regarding these ongoing symptoms or his subsequent decrease in oral intake. During an interview on 8/25/26 at 10:57 a.m., nursing assistant (NA)-A identified that throughout July, R1 did not eat much, required significant encouragement to consume meals, and frequently threw up after eating. NA-A confirmed that she regularly reported these poor intakes and ongoing episodes of nausea and vomiting directly to the charge nurse. During a phone interview on 8/25/26 at 2:52 p.m., licensed practical nurse (LPN)-A stated R1 had a lot of nausea and received ondansetron for it. LPN-A further stated she monitored R1's eating because he did not eat as much and would only eat about one-quarter of his meals. During a phone interview on 8/26/26 at 1:04 p.m., nurse practitioner (NP)-A identified that nurses should be watching hydration status for a resident with kidney failure and notifying her if he was potentially becoming dehydrated. NP-A stated that if she had been told he was not eating and drinking, she would have conducted a visit. NP-A identified that had she been notified he was taking ondansetron and had ongoing nausea, she would have conducted an in-person visit and ordered a BMP (Basic Metabolic Panel, a blood test used to check kidney function). NP-A identified that staff did not call her about any issues until 5:45 p.m. on 7/27/26 regarding family concerns about confusion. R3 R3's face sheet printed 8/26/26, identified diagnoses of rheumatoid arthritis (a chronic inflammatory disorder affecting joints), lymphedema (severe swelling caused by fluid buildup), nutritional deficiency (severe malnutrition), and dependence on supplemental oxygen. R3's annual minimum data set (MDS) dated 1/10/26, identified R3's cognition was intact. The assessment identified R3 used a walker for mobility and required setup assistance with dressing. The documentation	F0580		09/24/2026

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F0580 SS = D	Continued from page 9 further identified R3 was at risk for skin injuries and required the application of ointments or protective medications other than to feet. R3’s medical doctor (MD) visit note dated 7/21/26, identified a visit for a long-term care review. The note identified R3's skin was warm and dry, with no rashes or lesions on exposed skin. R3’s skin check document dated 8/16/26, identified a new in-house acquired skin tear on the right gluteal fold of unknown onset measuring 1 centimeter (cm) x 0.5 cm. The assessment failed to document any clinical suggestions, wound characteristics, or provider notification. R3’s progress note dated 8/16/26 at 3:12 p.m., identified an in-house acquired skin tear on the right gluteal fold. The note identified the injury was a new wound with no skin loss and it was unknown how long the injury had been present. The documentation recorded the skin tear measured 1 cm x 0.5 cm and showed no signs or symptoms of infection. R3’s order summary dated 8/16/26, did not identify a treatment plan for any skin alterations. Review of R3’s medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the development of this in-house acquired skin injury. R3’s progress note dated 8/23/26 at 10:03 a.m., identified a weekly skin check was completed. The note documented that the in-house acquired skin tear on the right gluteal fold remained unevaluated, with no wound characteristics, measurements, or treatments identified. During an interview on 8/24/26 at 1:50 p.m., licensed practical nurse (LPN)-B identified that R3 reported needing a Mepilex (a protective foam dressing) for a sore on her buttocks. LPN-B stated she had never visualized the wound and noted there were no current orders for wounds or dressings on the treatment administration record (TAR). During an observation and interview on 8/24/26 at 1:52 p.m., R3 was seated on her bed and stated she had a very painful sore on her bottom for the past five days. During an interview on 8/24/26 at 1:55 p.m., licensed practical nurse (LPN)-B stated she visualized a nickel-sized area of red and irritated skin on the right-side midline by the intergluteal	F0580		09/24/2026

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F0580 SS = D	Continued from page 10 cleft (the crack of the buttocks). LPN-B reported that urine caused a burning sensation on the area. LPN-B confirmed there were no medical treatment orders in place for the sore, she had not been informed about the injury by previous shifts. Review of R3's medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the ongoing presence of this skin injury. R3's progress note dated 8/24/26 at 2:19 p.m., identified R3 reported sustaining a rough area on her right inner buttock after applying a pull-up brief incorrectly and sitting on it. The note identified R3 requested a foam dressing for protection, and the area measured 1.7 cm by 2 cm with intact skin and dry tissue. The documentation showed a new physician order was received to apply a Mepilex (a protective foam dressing) every three days and as needed for skin protection. During an interview on 8/25/26 at 2:34 p.m., registered nurse (RN) quality assurance director (QAD)-A stated when the skin alteration was first discovered on 8/16/26, staff should have immediately notified the medical provider to ensure a treatment plan for healing was put in place. During a phone interview on 8/26/26 at 1:04 p.m., nurse practitioner (NP)-A stated that any change in skin condition should be reported to the provider immediately to ensure appropriate treatment was in place for healing and prevent further skin breakdown. Facility policy, Notification of Changes, dated 6/1/26, identified the purpose of the policy was to ensure the facility promptly informs the resident, consults the resident's physician, and notifies the resident's representative when there is a change requiring notification. The policy identified clinical complications included the development of a stage 2 pressure injury. The document defined a need to alter treatment significantly as a need to stop a form of treatment because of adverse consequences or commence a new form of treatment to deal with a problem. The compliance guidelines mandated that the facility must consult with the resident's physician and notify the resident's family member or legal representative when there is a significant change in the resident's physical, mental, or psychosocial condition, a deterioration in health, or a circumstance that requires a need to alter treatment.	F0580		09/24/2026

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F0580 SS = D	Continued from page 11 Facility policy for notifying the physician was requested and not received.	F0580		09/24/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the physician, assess, and monitor non-pressure-related skin injuries for changes until resolved for 1 of 1 (R3) residents reviewed for quality of care. Findings include R3’s face sheet printed 8/26/26, identified diagnoses of rheumatoid arthritis (a chronic inflammatory disorder affecting joints), lymphedema (severe swelling caused by fluid buildup), nutritional deficiency (severe malnutrition), and dependence on supplemental oxygen. R3’s annual Minimum Data Set (MDS) dated 1/10/26, identified R3’s cognition was intact. The assessment identified R3 used a walker for mobility and required setup assistance with dressing. The documentation further identified R3 was at risk for skin injuries and required the application of ointments or protective medications other than to feet. R3’s care area assessment (CAA) dated 1/20/26, identified R3 was at an actual high risk for impaired skin integrity. The assessment identified R3’s risk factors included chronic obstructive pulmonary disease (COPD) with oxygen dependence, oxygen tubing use, edema, and malnutrition status. The analysis concluded that the care plan would focus on minimizing skin risks and avoiding complications. R3’s care plan revised 7/6/26, identified a focus for a potential impairment to skin integrity related to a dependency on staff for cares and the use of assistive devices. Interventions dated 7/24/25, directed staff to observe R3's skin during cares and	F0684	F684 Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. Description of Correction: 1. Corrective Action for Identified Resident: R3’s skin alteration has been assessed and documented. The resident’s provider was notified, treatment orders were obtained and implemented as indicated, and the skin alteration will continue to be monitored until resolved. 2. Identification of Other Residents Potentially Affected: The DON or designee will review all current residents for pressure injury, moisture associated skin damage, skin alterations or other identified skin risk issues. Licensed nurses will perform a current body audit, complete provider notification, treatment orders obtained as needed, identify pressure relief needs and update care plans as indicated. 3. Systemic Changes: Policies related to skin assessment and change in condition were reviewed and appropriate as written. Nursing staff will complete weekly and PRN head-to-toe skin audits on all residents. Staff will assess for new or existing abnormal skin condition, document findings in the EHR, notify providers and obtain treatment orders timely and as indicated. All	09/24/2026

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F0684 SS = D	Continued from page 12 report changes to the nurse. The plan mandated staff to observe and document the location, size, and treatment of any skin injury, and to report any abnormalities or failures to heal directly to the medical practitioner. R3's medical doctor (MD) visit note dated 7/21/26, identified a visit for a long-term care review. The note identified R3's skin was warm and dry, with no rashes or lesions on exposed skin. R3's skin check document dated 8/16/26, identified a new in-house acquired skin tear on the right gluteal fold of unknown onset measuring 1 centimeter (cm) x 0.5 cm. The assessment failed to document any clinical suggestions, wound characteristics, or provider notification. R3's progress note dated 8/16/26 at 3:12 p.m., identified an in-house acquired skin tear on the right gluteal fold. The note identified the injury was a new wound with no skin loss and it was unknown how long the injury had been present. The documentation recorded the skin tear measured 1 cm x 0.5 cm and showed no signs or symptoms of infection. No other characteristics such as (but not limited to) color, drainage, and pain. R3's order summary dated 8/16/26, did not identify a treatment plan for any skin alterations. Review of R3's medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the development of this in-house acquired skin injury. The documentation further failed to identify any specific wound characteristics, protective nursing interventions, or medical treatment orders put in place to manage the skin damage. R3's progress note dated 8/23/26 at 10:03 a.m., identified a weekly skin check was completed. The note documented that the in-house acquired skin tear on the right gluteal fold remained unevaluated, with no wound characteristics, measurements, or treatments identified. During an interview on 8/24/26 at 1:50 p.m., licensed practical nurse (LPN)-B identified that R3 reported needing a Mepilex (a protective foam dressing) for a sore on her buttocks. LPN-B stated she had never visualized the wound and noted there were no current orders for wounds or dressings on the treatment administration record (TAR). LPN-B identified she did not know if the resident had a pressure injury and stated she intended to assess	F0684	Continued from page 12 staff will be educated on facility policy regarding skin assessment, change in condition, and appreciate response to resident requests. 4. Monitoring Plan: DON and/or designee will review skin audits and documentation daily Monday through Friday for new skin issues, changes in condition, discrepancies in documentation, provider notification, treatment orders, and evidence of worsening conditions. Findings will be followed up timely. Audits will occur 5x weekly for 30 days results will be reviewed by the QAPI Committee, which will evaluate compliance and determine whether additional monitoring or interventions are indicated. Education changes, and corrective action provided as indicated. Date Corrected: Woodbury Health Care Center will be in substantial compliance by 9.24.2026.	09/24/2026

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F0684 SS = D	Continued from page 13 the area and apply a dressing immediately. During an observation and interview on 8/24/26 at 1:52 p.m., R3 was seated on her bed and declined a request to observe her wound care due to privacy preferences. R3 stated she had a very painful sore on her bottom for the past five days. LPN-B then requested to examine R3's bottom to apply a Mepilex dressing. During an interview on 8/24/26 at 1:55 p.m., licensed practical nurse (LPN)-B stated she visualized a nickel-sized area of red and irritated skin on the right-side midline by the intergluteal cleft (the crack of the buttocks). LPN-B identified the skin was not open but R3 reported that urine caused a burning sensation on the area. LPN-B stated R3 had been applying a Mepilex dressing to the area herself and preferred privacy. LPN-B confirmed there were no medical treatment orders in place for the sore, she had not been informed about the injury by previous shifts, and she was unsure of the exact type of skin issue. Review of R3’s medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the ongoing presence of this skin injury. The documentation further failed to identify any measurements and characteristics of the wound, protective nursing interventions, or medical treatment orders put in place to manage the skin damage. R3’s progress note dated 8/24/26 at 2:19 p.m., identified R3 reported sustaining a rough area on her right inner buttock after applying a pull-up brief incorrectly and sitting on it. The note identified R3 requested a foam dressing for protection, and the area measured 1.7 cm by 2 cm with intact skin and dry tissue. The documentation showed a new physician order was received to apply a Mepilex (a protective foam dressing) every three days and as needed for skin protection. During an interview on 8/25/26 at 2:34 p.m., registered nurse (RN) quality assurance director (QAD)-A stated the nurse manager examined R3's buttocks and reported the area looked like flaky, dry skin rather than a pressure injury. QAD-A stated that R3 reported sitting on her pull-up brief incorrectly, which caused the irritation. QAD-A confirmed that any skin alteration should be initially measured, the wound type identified and comprehensively assessed weekly in a weekly wound assessment until healed. QAD-A further stated that when the skin alteration was first discovered on 8/16/26, staff should have	F0684		09/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD , WOODBURY, Minnesota, 55125

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F0684 SS = D	Continued from page 14 immediately notified the medical provider to ensure a treatment plan for healing was put in place. During a phone interview on 8/26/26 at 1:04 p.m., nurse practitioner (NP)-A stated that any change in skin condition should be reported to the provider immediately to ensure appropriate treatment was in place for healing and prevent further skin breakdown. R3's medical doctor (MD) visit dated 8/26/26, identified to monitor pressure sore in the coccygeal due to diaper per R3 advised to stay off pressure points. No new orders. Policy requested for non-pressure skin alterations was requested and not received.	F0684		09/24/2026
F0692 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- §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 document review, the facility failed to ensure 1 of 1 resident (R1) maintained acceptable parameters of hydration status to prevent renal complication, reviewed for quality of care. Findings include:	F0692	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. F692 1. Corrective Action for Identified Resident: R1 has discharged from the community. 2. Identification of Other Residents Potentially Affected: The interdisciplinary team will screen all current residents for nutrition high risk criteria, including kidney disease, fluid restrictions, diuretics, vomiting or diarrhea, recurrent low meal or fluid intake, or significant weight change. The nurse and dietitian will assess identified residents, establish individualized plans as appropriate, verify needed monitoring tasks in the EHR, and update care plans. Any acute concern will prompt same-day clinical assessment and practitioner contact.	09/24/2026

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F0692 SS = D	Continued from page 15 R1's Face sheet printed 8/19/26, identified diagnoses of chronic kidney disease stage 4 (severe kidney damage where the organ can no longer filter waste properly), metabolic encephalopathy (brain dysfunction and confusion caused by severe chemical imbalances in the body), and nutritional deficiency (severe malnutrition from a lack of food and fluids). R1's order summary dated 5/13/26, identified an order for sodium bicarbonate 650 mg (a medication used to balance high acid levels in the blood caused by kidney failure), two tablets twice a day. An additional order dated 6/15/26, directed staff to give ondansetron (an anti-nausea medication used to prevent throwing up) 4mg every 4 hours for nausea. R1's mini nutrition progress note dated 5/14/26, identified R1 has no decrease in food intake or weight loss in the last 3 months. Further identified R1 was at risk for malnutrition. R1's nutrition progress note dated 5/14/26 at 8:55 a.m., identified R1 was at risk for malnutrition related to a low assessment score. Risk factors included decreased mobility and severe illness. A malnutrition warning was completed and given to the floor nurse manager. The note stated staff would monitor weights and intakes. R1's admission minimum data set (MDS) assessment, dated 5/19/26, identified R1 had moderate cognitive impairment, required set up assist with eating and required a therapeutic diet. R1's care area assessment (CAA) dated 5/19/26, identified a need for special diet or altered consistency which might not appeal to R1. R1's care plan dated 5/19/26, identified a focus of potential for a nutritional problem related to a CSC (controlled carbohydrate) diet, metabolic encephalopathy, and CKD4 (stage 4 chronic kidney disease). Interventions dated 5/19/26 directed staff to provide and serve the diet as ordered. Staff were ordered to observe intake and record it every meal. An additional focus dated 5/22/26 identified a risk for malnutrition and directed staff to provide oral supplements between meals as needed. R1's care plan failed to address R1's high risk for dehydration due to his stage 4 chronic kidney disease, where damaged kidneys cannot properly balance fluids and waste. The care plan failed to include interventions to monitor fluid intake.	F0692	Continued from page 15 3. Systemic Changes: Polices related to Nutrition at Risk, Hydration, and Nutrition Management were reviewed and are appropriate as written. Nursing staff and the community dietitian were educated on accurate documentation of oral intake, completion of hydration-monitoring records, identification and communication of changes in intake, and appropriate follow-up when intake is inadequate or declining. Risks for malnutrition and dehydration will be assessed the Registered Dietitian upon admission and as indicated thereafter via the Nutritional Assessment in the EHR. Resident health history, risk factors, and changes in condition will be evaluated to determine the need for supplements, I&O monitoring, dietary interventions, or other individualized interventions. Meal and fluid intake will be monitored and documented after each meal to identify changes in intake patterns. Nursing, CNA, and Dietary staff will record intake prior to removal of consumed trays from the dining room or resident rooms. Signage/samples of fluid volume were laminated and distributed and audited randomly to ensure that they are available for reference. The Registered Dietitian will review identified at risk for malnutrition and dehydration residents with decreased meal or fluid intake on a weekly basis and make recommendations for additional interventions as indicated. 4. Monitoring Plan: Licensed staff will complete a random sample of 6 residents deemed at risk for malnutrition and/or dehydration per week for 4 weeks comparing documented fluid intake with observed intake. If determined in compliance QA team will reduce to weekly. Results will be reviewed by the QAPI Committee, which will evaluate compliance and determine whether additional monitoring or interventions are indicated. Education changes, and corrective action provided as indicated. Date Corrected: Woodbury Health Care Center will be in substantial compliance by 9.24.2026.	09/24/2026

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F0692 SS = D	Continued from page 16 R1's nutritional assessment dated 5/19/26, identified R1's estimated fluid requirement was 2708 cubic centimeters (CC's) per day and consumed greater than 2,000 cc of fluids per day. R1 explained appetite hasn't been the best but was starting to improve. R1's progress note dated 5/31/26, identified R1 refused his sodium bicarbonate 650 mg tablet due to making him vomit. R1's progress note dated 6/4/26 at 11:54 a.m., identified R1 vomited after taking his morning medication and blamed the sodium bicarbonate tablets. An additional note at 4:47 p.m. identified R1 refused the medication until he could see his provider. The provider was notified and wanted R1 to continue the medication. R1's nurse practitioner (NP) visit note dated 6/8/26, identified R1 was seen for a follow-up. R1 reported vomiting at breakfast and lunch most days and felt it was related to the sodium bicarbonate pill (medication used to balance blood acid levels caused by kidney failure). New orders were received to discontinue (stop) the morning dose of sodium bicarbonate due to vomiting, but to continue the afternoon dose. R1's progress note dated 6/10/26 at 1:28 p.m., identified R1 was sent to the hospital due to hypotension (dangerous low blood pressure). The note showed R1 was tired and sleepy, and staff pushed fluids before the transfer. R1's after-visit summary (AVS) dated 6/10/26, identified R1's history of dialysis earlier in the year and a solitary (single functioning) kidney. R1 was seen for hypotension (dangerous low blood pressure) and stage 4 kidney disease. R1 had instructions to continue previously prescribed medications, including midodrine (a medication used to raise low blood pressure). The summary included an additional instruction to drink plenty of fluids to stay hydrated (keeping enough water in the body). R1's progress note dated 6/11/26 at 4:00 p.m., identified an order for sodium bicarbonate 650 mg to be given in the evening. R1 refused to take this medication and stated that it made him sick and upset his stomach. R1's nurse practitioner (NP) recheck visit dated 6/15/26, identified R1 was seen for a hospital follow-up and was encouraged to ensure adequate oral hydration (drinking enough fluids). New orders were received to check a BMP (Basic Metabolic	F0692		09/24/2026

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F0692 SS = D	Continued from page 17 Panel, a blood test used to check kidney function and chemical balance) on 6/17/26. R1's progress note dated 6/22/26 at 10:14 a.m., identified ondansetron HCL 4mg tablet given due to R1 vomiting that morning. At 11:40 a.m., identified the medication was effective. R1's progress note dated 6/29/26 at 2:57 p.m., identified ondansetron 4mg was given for nausea and at 5:03 p.m., was noted to be effective. R1's progress note dated 6/30/26 at 1:03 a.m., identified ondansetron 4mg was given for nausea and at 3:11 a.m., was noted to be effective. R1's progress note dated 6/30/26 at 8:41 a.m., identified R1 reported feeling nauseous and received PRN (as-needed) ondansetron. The note further identified R1 was hungry but refused to eat solid foods, drinking only the broth from a can of soup and sipping on water. R1's progress note dated 7/1/26, at 8:36 a.m., identified ondansetron 4mg was given for nausea and at 1:07 p.m., was noted to be effective. R1's progress note dated 7/16/26, at 9:41 a.m., identified ondansetron 4mg was given due to R1 being nauseated after breakfast nausea and at 2:01 p.m., was noted to be effective. R1's progress note on 7/19/26, at 10:53 p.m., identified R1 had an episode of diarrhea shortly after eating food purchased by family and staff encouraged fluids. R1's progress note dated 7/24/26 at 8:11 p.m., identified ondansetron 4mg was given for nausea and at 8:42 p.m., was noted to be effective. R1's progress note dated 7/25/26 at 4:26 p.m., identified ondansetron 4mg was given for nausea and vomiting his lunch and at 8:39 p.m., was noted to be effective. Review of R1's medical record identified a failure to implement a fluid tracking system or record R1's actual daily fluid intake, despite administering multiple doses of anti-nausea medication for ongoing stomach distress. R1's progress note dated 7/27/26 at 5:33 p.m., identified a family member called and was very upset about R1's confusion since the previous day. The family member demanded an immediate assessment.	F0692		09/24/2026

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F0692 SS = D	Continued from page 18 The note identified that the family member rejected a basic lab test and demanded R1 be sent to the hospital for a thorough assessment. Staff called the provider and received an order to send R1 to the emergency room per the family's request. R1’s progress note dated 7/28/26 at 5:39 p.m., identified R1 was sent to the emergency room on 7/27/26, and was treated for hypotension (dangerous low blood pressure) of 71/41, shock (a life-threatening drop in blood flow), hypoglycemia (dangerous low blood sugar) with a glucose level of 25, and acute on chronic renal failure (sudden kidney collapse). The note identified his creatinine (a waste product filtered by the kidneys) was at 8.39, proving severe kidney failure. R1’s hospital notes dated 7/27/26, identified R1 arrived at the emergency room with a dangerous low blood pressure of 70/40. The notes showed R1 was severely acidotic with a blood pH of 7.18 (severe acid buildup in the blood) caused by worsening renal failure (kidney collapse). R1's creatinine had spiked from a baseline of 3.0 in June to an acute level of 8.0, and his GFR (kidney filtering rate) dropped to a near-deadly level of 7. The notes further identified R1 was profoundly hypoglycemic (dangerously low blood sugar) because he had a multi-week history of not really eating or drinking and had refused most oral intake at his care center. The hospital provider concluded that this fluid and food starvation was the direct cause of his acute kidney collapse, low blood pressure, and low blood sugar. R1’s hospital discharge summary dated 7/30/26, identified R1 was admitted from a long-term care facility on 7/27/26 for hypotension (dangerous low blood pressure), severe acute kidney injury (sudden kidney collapse), and metabolic acidosis (severe acid buildup in the blood). The summary identified the family decided to transition R1 to comfort care on 7/28/26, and he passed away on 7/30/26. The final synopsis listed the cause of death as renal failure (kidney collapse) due to septic shock (a life-threatening infection response) and cardiogenic shock (heart pump failure). Review of R1’s medical record identified a failure to record fluid inputs or monitor R1's hydration status, allowing a multi-week fluid deficit to progress unmanaged until his single kidney completely collapsed. Review of the facility's active electronic treatment sheets throughout July 2026, identified that staff possessed active electronic tasks to track solid food	F0692		09/24/2026

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F0692 SS = D	Continued from page 19 intake. The documentation identified that the facility failed to initialize, activate, or assign a specific electronic tracking task within the PointClickCare system for staff to log R1's daily fluid inputs. During a phone interview on 8/24/26 at 9:45 a.m., family member (FM)-A identified she called R1 on 7/27/26. R1 stated to FM-A that he had not consumed fluids for days. FM-A called the nursing station and requested laboratory tests to be completed. Facility staff refused and stated they would not perform labs until Wednesday. FM-A demanded that the facility call 911 to get R1 evaluated. During an interview on 8/25/26 at 10:57 a.m., nursing assistant (NA)-A stated that staff did not document fluid intake because there was designated place in the electronic record system to record it. NA-A stated throughout July R1 did not eat much, requiring significant encouragement to consume meals, and frequently threw up after eating. NA-A further stated that R1 was adamant about not wanting his food or fluids so the left-over trays were thrown away. NA-A confirmed she regularly reported these poor intakes and ongoing episodes of nausea and vomiting directly to the nurse on duty. During an interview on 8/25/26 at 12:33 p.m., the certified food production manager (CFPM)-A stated R1 had renal failure and required monitoring for hypovolemia (low blood fluid levels). (CFPM)-A verified there were no medical orders or electronic point-of-care tasks put in place for fluid monitoring, noting that the facility only monitored fluids if a doctor specifically ordered it. (CFPM)-A confirmed that neither nursing nor social services ever submitted a formal dietary consult or notified the dietary department that R1 was persistently nauseated, refused regular meals, or relied on outside liquids, and stated that the department would have assessed R1 immediately had they been notified. During a phone interview on 8/25/26 at 2:52 p.m., licensed practical nurse (LPN)-A identified R1 ate only about one-quarter of his meals. LPN-A stated R1 had a lot of nausea and received ondansetron prn. LPN-A identified she was not sure if R1 had kidney disease. LPN-A further stated that if there was no task to document fluids in the electronic system, she was unable to monitor his fluid intake. During a phone interview on 8/25/26 at 3:05 p.m., registered nurse (RN)-A identified that R1 would not finish the small cup of water given with his	F0692		09/24/2026

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F0692 SS = D	Continued from page 20 medications and was not drinking much. RN-A stated that because fluid intake was not documented in the electronic system, staff had no way to review fluid logs or check if R1 met his hydration targets. RN-A identified he was unaware that R1 had a history of dialysis or kidney disease. RN-A further stated that when FM-A called on 7/27/26 regarding R1's confusion, he told her that routine blood work would take two days to process because of when the lab company visited the facility, leading to the decision to transfer R1 to the hospital. During an interview on 8/25/26 at 2:23 p.m., registered nurse (RN) quality assurance director (QAD)-A, who was acting as the director of nursing (DON), identified the facility did not have a policy for monitoring fluids. QAD-A stated that staff found no documentation regarding R1's fluid intake. QAD-A identified that the facility only monitors fluid intake if a doctor explicitly orders it. QAD-A confirmed that a resident who is care-planned to be monitored for a fluid deficit (severe dehydration) or overload due to kidney disease should have documentation of fluid intake so the provider can be notified of a change for ongoing direction. During a phone interview on 8/26/26 at 1:04 p.m., nurse practitioner (NP)-A stated that nurses managing residents with kidney failure should actively monitor hydration and report signs of dehydration or decreased oral intake. The practitioner noted that had she been informed of ongoing nausea, she would have conducted an in-person assessment and ordered a basic metabolic panel. Facility policy for hydration/fluid monitoring was requested and not received.	F0692		09/24/2026

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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: On 8/24/26, 8/25/26, 8/26/26, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H52353864C (3171398) with a licensing order issued at 0265, 0830, 0900 and 0940.	20000		09/15/2026

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

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20000	Continued from page 1 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 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.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of	20265	F580 Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	09/24/2026

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WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD , WOODBURY, Minnesota, 55125**

(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
20265	Continued from page 2 these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to notify the physician with change in condition who required prn medication for nausea and vomiting for 1 of 1 resident (R1) and for 1 of 1 resident (R3) who developed a non pressure skin lesion. Findings include Findings include: R1's face sheet printed 8/26/26, identified diagnoses of chronic kidney disease stage 4 (severe kidney damage), metabolic encephalopathy (brain dysfunction causing confusion), and nutritional deficiency (severe malnutrition). R1's order summary dated 5/13/26, identified an order for sodium bicarbonate 650 mg (a medication used to balance high acid levels in the blood caused by kidney failure), two tablets twice a day. An additional order dated 6/15/26, directed staff to give ondansetron 4 mg (an anti-nausea medication used to prevent throwing up) every 4 hours as needed for nausea.	20265	Continued from page 2 This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. Description of Correction: 1. Corrective Action for Identified Residents: R1 has discharged from the community. R3 was reviewed by nursing. The changes in condition were assessed and documented, and the appropriate provider was notified. Orders and interventions were obtained and implemented as indicated. 2. Identification of Other Residents Potentially Affected: DON or designee will review current residents for new skin alterations, repeated nausea or vomiting, declining intake, repeated PRN use for an unresolved symptom, or other significant condition changes in the preceding 14 days. All changes in condition identified in the review will be audited for timely physician consultation, resident and representative notification if required, and follow-up documentation with interventions initiated as indicated. 3. Systemic Changes: . The policy related to provider notification has been reviewed and updated. RNs and LPNs will be educated on identifying and responding to changes in condition including changes in medication regimen, including timely assessment, documentation, provider notification, obtaining orders, and follow-up. CNAs will be educated on recognizing changes from a resident’s normal habits, condition, or behavior and the importance of immediately reporting changes to the licensed nurse for further assessment and monitoring. Don and/or designee will review and audit the 24-hour report including progress notes daily. Don and/or designee to elevate action items for appropriate follow up. 4. Monitoring Plan:	09/24/2026

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20265	Continued from page 3 R1’s admission Minimum Data Set (MDS) assessment dated 5/19/26, identified R1 had moderate cognitive impairment and entered the facility with one stage 2 pressure ulcer. R1’s progress note dated 6/4/26, identified R1 vomited after taking his morning medication and blamed the sodium bicarbonate tablets. An additional note at 4:47 p.m. identified R1 refused the medication until he could see his provider. The provider was notified and wanted R1 to continue the medication. R1’s nurse practitioner (NP) visit note dated 6/8/26, identified R1 reported vomiting at breakfast and lunch most days and felt it was related to the sodium bicarbonate pill. New orders were received to discontinue (stop) the morning dose of sodium bicarbonate due to vomiting, but to continue the afternoon dose. R1’s progress note dated 6/11/26 at 4:00 p.m., identified R1 refused to take his evening dose of sodium bicarbonate and stated that it made him sick and upset his stomach. R1’s progress note dated 6/22/26 at 10:14 a.m., identified ondansetron 4 milligrams (mg) was given because R1 vomited that morning. R1’s progress note dated 6/29/26 at 2:57 p.m., identified ondansetron 4 mg was given for nausea. R1’s progress note dated 6/30/26 at 1:03 a.m., identified ondansetron 4 mg was given for nausea. R1’s progress note dated 6/30/26 at 8:41 a.m., identified R1 reported feeling nauseous and received PRN (as-needed) ondansetron. The note further identified R1 was hungry but refused to eat solid foods, drinking only broth and sipping on water. R1’s progress note dated 7/1/26 at 8:36 a.m., identified ondansetron 4 mg was given for nausea. R1’s progress note dated 7/16/26 at 9:41 a.m., identified ondansetron 4 mg was given because R1 was nauseated after breakfast. R1’s progress note dated 7/24/26 at 8:11 p.m., identified ondansetron 4 mg was given for nausea. R1’s progress note dated 7/25/26 at 4:26 p.m., identified ondansetron 4 mg was given for nausea and vomiting his lunch. Review of R1’s medical records identified that	20265	Continued from page 3 DON and/or designee will audit the 24-hour report including progress notes 3x weekly for 3 months for appropriate provider notifications. Results of audits will be reviewed by the QAPI Committee, which will evaluate compliance and determine whether additional monitoring or interventions are indicated. Education changes, and corrective action provided as indicated. Date Corrected: Woodbury Health Care Center will be in substantial compliance by 9.24.2026.	09/24/2026

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20265	Continued from page 4 licensed nursing staff repeatedly identified ongoing nausea, vomiting, and food refusals requiring multiple administrations of anti-nausea medication throughout June and July 2026. The facility documentation failed to identify any phone calls, faxes, or notifications to the medical practitioner regarding these ongoing symptoms or his subsequent decrease in oral intake. During an interview on 8/25/26 at 10:57 a.m., nursing assistant (NA)-A identified that throughout July, R1 did not eat much, required significant encouragement to consume meals, and frequently threw up after eating. NA-A confirmed that she regularly reported these poor intakes and ongoing episodes of nausea and vomiting directly to the charge nurse. During a phone interview on 8/25/26 at 2:52 p.m., licensed practical nurse (LPN)-A stated R1 had a lot of nausea and received ondansetron for it. LPN-A further stated she monitored R1’s eating because he did not eat as much and would only eat about one-quarter of his meals. During a phone interview on 8/26/26 at 1:04 p.m., nurse practitioner (NP)-A identified that nurses should be watching hydration status for a resident with kidney failure and notifying her if he was potentially becoming dehydrated. NP-A stated that if she had been told he was not eating and drinking, she would have conducted a visit. NP-A identified that had she been notified he was taking ondansetron and had ongoing nausea, she would have conducted an in-person visit and ordered a BMP (Basic Metabolic Panel, a blood test used to check kidney function). NP-A identified that staff did not call her about any issues until 5:45 p.m. on 7/27/26 regarding family concerns about confusion. R3 R3’s face sheet printed 8/26/26, identified diagnoses of rheumatoid arthritis (a chronic inflammatory disorder affecting joints), lymphedema (severe swelling caused by fluid buildup), nutritional deficiency (severe malnutrition), and dependence on supplemental oxygen. R3’s annual minimum data set (MDS) dated 1/10/26, identified R3’s cognition was intact. The assessment identified R3 used a walker for mobility and required setup assistance with dressing. The documentation further identified R3 was at risk for skin injuries and required the application of ointments or protective medications other than to feet.	20265		09/24/2026

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20265	Continued from page 5 R3’s medical doctor (MD) visit note dated 7/21/26, identified a visit for a long-term care review. The note identified R3's skin was warm and dry, with no rashes or lesions on exposed skin. R3’s skin check document dated 8/16/26, identified a new in-house acquired skin tear on the right gluteal fold of unknown onset measuring 1 centimeter (cm) x 0.5 cm. The assessment failed to document any clinical suggestions, wound characteristics, or provider notification. R3’s progress note dated 8/16/26 at 3:12 p.m., identified an in-house acquired skin tear on the right gluteal fold. The note identified the injury was a new wound with no skin loss and it was unknown how long the injury had been present. The documentation recorded the skin tear measured 1 cm x 0.5 cm and showed no signs or symptoms of infection. R3’s order summary dated 8/16/26, did not identify a treatment plan for any skin alterations. Review of R3’s medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the development of this in-house acquired skin injury. R3’s progress note dated 8/23/26 at 10:03 a.m., identified a weekly skin check was completed. The note documented that the in-house acquired skin tear on the right gluteal fold remained unevaluated, with no wound characteristics, measurements, or treatments identified. During an interview on 8/24/26 at 1:50 p.m., licensed practical nurse (LPN)-B identified that R3 reported needing a Mepilex (a protective foam dressing) for a sore on her buttocks. LPN-B stated she had never visualized the wound and noted there were no current orders for wounds or dressings on the treatment administration record (TAR). During an observation and interview on 8/24/26 at 1:52 p.m., R3 was seated on her bed and stated she had a very painful sore on her bottom for the past five days. During an interview on 8/24/26 at 1:55 p.m., licensed practical nurse (LPN)-B stated she visualized a nickel-sized area of red and irritated skin on the right-side midline by the intergluteal cleft (the crack of the buttocks). LPN-B reported that urine caused a burning sensation on the area. LPN-B confirmed there were no medical treatment	20265		09/24/2026

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20265	Continued from page 6 orders in place for the sore, she had not been informed about the injury by previous shifts. Review of R3's medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the ongoing presence of this skin injury. R3's progress note dated 8/24/26 at 2:19 p.m., identified R3 reported sustaining a rough area on her right inner buttock after applying a pull-up brief incorrectly and sitting on it. The note identified R3 requested a foam dressing for protection, and the area measured 1.7 cm by 2 cm with intact skin and dry tissue. The documentation showed a new physician order was received to apply a Mepilex (a protective foam dressing) every three days and as needed for skin protection. During an interview on 8/25/26 at 2:34 p.m., registered nurse (RN) quality assurance director (QAD)-A stated when the skin alteration was first discovered on 8/16/26, staff should have immediately notified the medical provider to ensure a treatment plan for healing was put in place. During a phone interview on 8/26/26 at 1:04 p.m., nurse practitioner (NP)-A stated that any change in skin condition should be reported to the provider immediately to ensure appropriate treatment was in place for healing and prevent further skin breakdown. Facility policy, Notification of Changes, dated 6/1/26, identified the purpose of the policy was to ensure the facility promptly informs the resident, consults the resident's physician, and notifies the resident's representative when there is a change requiring notification. The policy identified clinical complications included the development of a stage 2 pressure injury. The document defined a need to alter treatment significantly as a need to stop a form of treatment because of adverse consequences or commence a new form of treatment to deal with a problem. The compliance guidelines mandated that the facility must consult with the resident's physician and notify the resident's family member or legal representative when there is a significant change in the resident's physical, mental, or psychosocial condition, a deterioration in health, or a circumstance that requires a need to alter treatment. Facility policy for notifying the physician was requested and not received.	20265		09/24/2026

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20265	Continued from page 7 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, should review all residents experiencing significant changes in clinical condition, medication refusals, changes in skin integrity, or persistent symptoms to assure timely physician and family notifications are completed. The Director of Nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented, change of condition protocols are followed accurately, and medical provider notification parameters are maintained. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		09/24/2026
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the physician, assess, and monitor non-pressure-related skin injuries for changes until resolved for 1 of 1 (R3) residents reviewed for quality of care. Findings include: R3’s face sheet printed 8/26/26, identified diagnoses of rheumatoid arthritis (a chronic inflammatory disorder affecting joints), lymphedema (severe swelling caused by fluid buildup), nutritional deficiency (severe malnutrition), and dependence on supplemental oxygen. R3’s annual Minimum Data Set (MDS) dated 1/10/26,	20830	F684 Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. Description of Correction: 1. Corrective Action for Identified Resident: R3’s skin alteration has been assessed and documented. The resident’s provider was notified, treatment orders were obtained and implemented as indicated, and the skin alteration will continue to be monitored until resolved. 2. Identification of Other Residents Potentially Affected: The DON or designee will review all current	09/24/2026

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20830	Continued from page 8 identified R3's cognition was intact. The assessment identified R3 used a walker for mobility and required setup assistance with dressing. The documentation further identified R3 was at risk for skin injuries and required the application of ointments or protective medications other than to feet. R3's care area assessment (CAA) dated 1/20/26, identified R3 was at an actual high risk for impaired skin integrity. The assessment identified R3's risk factors included chronic obstructive pulmonary disease (COPD) with oxygen dependence, oxygen tubing use, edema, and malnutrition status. The analysis concluded that the care plan would focus on minimizing skin risks and avoiding complications. R3's care plan revised 7/6/26, identified a focus for a potential impairment to skin integrity related to a dependency on staff for cares and the use of assistive devices. Interventions dated 7/24/25, directed staff to observe R3's skin during cares and report changes to the nurse. The plan mandated staff to observe and document the location, size, and treatment of any skin injury, and to report any abnormalities or failures to heal directly to the medical practitioner. R3's medical doctor (MD) visit note dated 7/21/26, identified a visit for a long-term care review. The note identified R3's skin was warm and dry, with no rashes or lesions on exposed skin. R3's skin check document dated 8/16/26, identified a new in-house acquired skin tear on the right gluteal fold of unknown onset measuring 1 centimeter (cm) x 0.5 cm. The assessment failed to document any clinical suggestions, wound characteristics, or provider notification. R3's progress note dated 8/16/26 at 3:12 p.m., identified an in-house acquired skin tear on the right gluteal fold. The note identified the injury was a new wound with no skin loss and it was unknown how long the injury had been present. The documentation recorded the skin tear measured 1 cm x 0.5 cm and showed no signs or symptoms of infection. No other characteristics such as (but not limited to) color, drainage, and pain. R3's order summary dated 8/16/26, did not identify a treatment plan for any skin alterations. Review of R3's medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the development of this in-house acquired skin injury. The documentation	20830	Continued from page 8 residents for pressure injury, moisture associated skin damage, skin alterations or other identified skin risk issues. Licensed nurses will perform a current body audit, complete provider notification, treatment orders obtained as needed, identify pressure relief needs and update care plans as indicated. 3. Systemic Changes: Policies related to skin assessment and change in condition were reviewed and appropriate as written. Nursing staff will complete weekly and PRN head-to-toe skin audits on all residents. Staff will assess for new or existing abnormal skin condition, document findings in the EHR, notify providers and obtain treatment orders timely and as indicated. All staff will be educated on facility policy regarding skin assessment, change in condition, and appreciate response to resident requests. 4. Monitoring Plan: DON and/or designee will review skin audits and documentation daily Monday through Friday for new skin issues, changes in condition, discrepancies in documentation, provider notification, treatment orders, and evidence of worsening conditions. Findings will be followed up timely. Audits will occur 5x weekly for 30 days results will be reviewed by the QAPI Committee, which will evaluate compliance and determine whether additional monitoring or interventions are indicated. Education changes, and corrective action provided as indicated. Date Corrected: Woodbury Health Care Center will be in substantial compliance by 9.24.2026.	09/24/2026

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20830	Continued from page 9 further failed to identify any specific wound characteristics, protective nursing interventions, or medical treatment orders put in place to manage the skin damage. R3's progress note dated 8/23/26 at 10:03 a.m., identified a weekly skin check was completed. The note documented that the in-house acquired skin tear on the right gluteal fold remained unevaluated, with no wound characteristics, measurements, or treatments identified. During an interview on 8/24/26 at 1:50 p.m., licensed practical nurse (LPN)-B identified that R3 reported needing a Mepilex (a protective foam dressing) for a sore on her buttocks. LPN-B stated she had never visualized the wound and noted there were no current orders for wounds or dressings on the treatment administration record (TAR). LPN-B identified she did not know if the resident had a pressure injury and stated she intended to assess the area and apply a dressing immediately. During an observation and interview on 8/24/26 at 1:52 p.m., R3 was seated on her bed and declined a request to observe her wound care due to privacy preferences. R3 stated she had a very painful sore on her bottom for the past five days. LPN-B then requested to examine R3's bottom to apply a Mepilex dressing. During an interview on 8/24/26 at 1:55 p.m., licensed practical nurse (LPN)-B stated she visualized a nickel-sized area of red and irritated skin on the right-side midline by the intergluteal cleft (the crack of the buttocks). LPN-B identified the skin was not open but R3 reported that urine caused a burning sensation on the area. LPN-B stated R3 had been applying a Mepilex dressing to the area herself and preferred privacy. LPN-B confirmed there were no medical treatment orders in place for the sore, she had not been informed about the injury by previous shifts, and she was unsure of the exact type of skin issue. Review of R3's medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the ongoing presence of this skin injury. The documentation further failed to identify any measurements and characteristics of the wound, protective nursing interventions, or medical treatment orders put in place to manage the skin damage. R3's progress note dated 8/24/26 at 2:19 p.m., identified R3 reported sustaining a rough area on	20830		09/24/2026

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20830	Continued from page 10 her right inner buttock after applying a pull-up brief incorrectly and sitting on it. The note identified R3 requested a foam dressing for protection, and the area measured 1.7 cm by 2 cm with intact skin and dry tissue. The documentation showed a new physician order was received to apply a Mepilex (a protective foam dressing) every three days and as needed for skin protection. During an interview on 8/25/26 at 2:34 p.m., registered nurse (RN) quality assurance director (QAD)-A stated the nurse manager examined R3's buttocks and reported the area looked like flaky, dry skin rather than a pressure injury. QAD-A stated that R3 reported sitting on her pull-up brief incorrectly, which caused the irritation. QAD-A confirmed that any skin alteration should be initially measured, the wound type identified and comprehensively assessed weekly in a weekly wound assessment until healed. QAD-A further stated that when the skin alteration was first discovered on 8/16/26, staff should have immediately notified the medical provider to ensure a treatment plan for healing was put in place. During a phone interview on 8/26/26 at 1:04 p.m., nurse practitioner (NP)-A stated that any change in skin condition should be reported to the provider immediately to ensure appropriate treatment was in place for healing and prevent further skin breakdown. R3’s medical doctor (MD) visit dated 8/26/26, identified to monitor pressure sore in the coccygeal due to diaper per R3 advised to stay off pressure points. No new orders. Policy requested for non-pressure skin alterations was requested and not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, should review all residents experiencing new or existing skin alterations, including skin tears and non-pressure wounds, to assure they are receiving the necessary treatment and services to promote healing, manage pain, and track wound characteristics and measurements. The Director of Nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care, weekly comprehensive assessments, and treatment services are implemented, and timely physician notification parameters are maintained. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI)	20830		09/24/2026

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20830	Continued from page 11 committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		09/24/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, evaluate, and implement individualized interventions to prevent/treat pressure ulcers, including timely physician notification for 1 of 3 residents (R1) reviewed for pressure ulcers. The facility’s failures resulted in harm when R1’s moisture associated skin damage deteriorated to a stage 3 pressure ulcer. Findings include: Moisture-Associated Skin Damage (MASD): Inflammation and erosion of the skin caused by prolonged or continuous exposure to moisture and chemical irritants, including urine, feces, sweat, or wound drainage. This exposure breaks down the skin's protective acid mantle and lipids, causing overhydration and maceration (softening and wrinkling of the tissue). Wounds are typically superficial, affecting the top layers of skin with diffuse, irregular edges, and are not classified by stages. Incontinence-associated dermatitis (IAD) is the most common form. While MASD involves partial-thickness skin loss, it can quickly convert to	20900	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. F686 Description of Correction: 1. Corrective Action for Identified Resident: R1 has discharged from the community . The leadership team will complete and document a retrospective review of the July 13 to July 28 medical record to review for skin changes, assessment and staging, provider notification, orders, moisture management, repositioning, nutrition, care plan, and escalation. Findings will be referred to QAPI and used in staff education. 2. Identification of Other Residents Potentially Affected: The DON or designee will review all current residents for pressure injury, moisture associated skin damage, skin alterations or other identified skin risk issues. Licensed nurses will perform a current body audit for all residents and complete provider notification, obtain treatment orders, evaluate current interventions for effectiveness and update care plans as indicated. 3. Systemic Changes:	09/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD , WOODBURY, Minnesota, 55125**

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20900	Continued from page 12 a pressure injury if underlying pressure or shearing forces are also present Stage 3 Pressure Ulcer: Full-thickness skin loss, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI (pressure ulcer/pressure injury). R1's Face sheet identified diagnoses of chronic kidney disease stage 4 (severe kidney damage where the organ can no longer filter waste properly), metabolic encephalopathy (brain dysfunction and confusion caused by severe chemical imbalances in the body), and nutritional deficiency (severe malnutrition from a lack of food and fluids). R1's admission Minimum Data Set (MDS) dated 5/19/26, identified R1 had moderate cognitive impairment and was dependent with toileting, dressing and transfers. R1 did not have behaviors including no rejection of care. Further identified R1 was at risk for pressure ulcers and had one stage 2 pressure ulcer upon admission. R1 had a pressure reducing device for bed and chair, nutrition hydration intervention to manage skin problems, pressure injury care, and application of ointments/medications other than to feet. R1's care area assessment (CAA) dated 5/19/26, identified R1 was at an actual risk for developing pressure ulcers. The assessment identified R1 required staff assistance for bed movement, required a special mattress or seat cushion to relieve pressure, and required a regular turning schedule. The analysis concluded that the care plan would focus on pressure relief, repositioning, incontinence management, and daily skin monitoring. R1's care plan revised 5/22/26, identified a focus of potential or actual impairment to skin integrity related to incontinence, a need for staff assistance with position changes, diabetes, and a risk of malnutrition and obesity. Interventions dated 5/15/26, directed staff to attempt to reposition R1 off the area, encourage good nutrition and hydration to promote healthier skin, and keep linens dry and wrinkle-free. The plan further directed staff to observe skin during cares, report changes to the	20900	Continued from page 12 Policies related to, pressure injury prevention, and skin assessment were reviewed and are appropriate as written. Policy related to provider notification has been reviewed and updated. Basic wound and skin integrity education will be provided to all clinical staff and will include identification of residents at risk for skin breakdown, signs and symptoms of developing skin damage, proactive prevention interventions, reevaluation of intervention effectiveness, timely reporting of skin alterations to licensed nursing staff, provider notification, obtaining treatment orders, and ongoing monitoring of skin alterations. Nursing staff will complete weekly and PRN skin audits on all residents. Any new or worsening skin condition will be assessed, documented, reported to the appropriate provider, wound prevention interventions initiated as indicated and the skin concerns will be monitored through resolution. 4. Monitoring Plan: DON and/or designee will review skin audits and documentation daily Monday through Friday for new skin issues, changes in condition, discrepancies in documentation, provider notification, treatment orders, and evidence of worsening conditions. Findings will be followed up timely. Audits will occur 5x weekly for 30 days. Results will be reviewed by the QAPI Committee, which will evaluate compliance and determine whether additional monitoring or interventions are indicated. Education changes, and corrective action provided as indicated. Woodbury Health Care Center will be in substantial compliance by 9.24.2026.	09/24/2026

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20900	Continued from page 13 nurse, offer toilet assistance before meals and at bedtime, and utilize pressure-relieving support surfaces in his bed and chair. An intervention dated 5/22/26 directed staff to complete a weekly skin inspection and as needed. R1’s progress note dated 6/14/26 at 2:29 p.m., identified a skin check was completed. The note showed R1's skin was warm and dry, skin color was within normal limits, and no skin issues were identified. R1’s progress note dated 6/26/2026 10:34 p.m., identified a skin check was completed. The note showed R1's skin was warm and dry, skin color was within normal limits, and no skin issues were identified. R1’s progress note dated 7/13/26 at 2:43 p.m., identified a new in-house acquired skin issue on the intergluteal cleft (the crack of the buttocks). The note identified the injury as moisture-associated skin damage (MASD) and incontinence-associated dermatitis (IAD)-(skin damage caused by prolonged exposure to urine or stool). The documentation showed that wound measurements were not recorded during this assessment. R1’s progress note dated 7/17/26 at 9:59 p.m., identified a weekly skin check was completed. The note identified the in-house acquired skin issue on the intergluteal cleft was MASD and IAD. Review of R1’s medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the development of this in-house acquired skin injury. The documentation further failed to identify any measurements and characteristics of the wound, protective nursing interventions, or medical treatment orders put in place to manage the skin damage. R1’s progress note dated 7/24/26 at 10:57 p.m., identified a weekly skin check was completed. The note identified the in-house acquired skin issue on the intergluteal cleft had transitioned to a pressure ulcer. The note documented that the wound was stable, but measurements were not recorded because the resident was uncooperative. Furthermore, did not identify what stage the pressure ulcer was. Review of R1’s medical records failed to identify any phone calls, faxes, or notifications to the medical provider regarding the development of this in-house acquired pressure ulcer. The documentation further	20900		09/24/2026

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20900	Continued from page 14 failed to identify any measurements and characteristics of the wound, protective nursing interventions, or medical treatment orders put in place to manage the pressure injury. R1’s nutrition progress note dated 7/27/26 at 12:15 p.m., identified R1 was at high risk related to wound healing for a pressure area on the intergluteal cleft. The note identified R1 had increased nutritional needs, and the dietitian would follow up on oral supplements. The documentation showed R1's meal intakes ranged from 25 percent to 100 percent, his weight was 197 pounds, and no significant weight loss or weight gain was recorded. R1’s hospital noted dated 7/28/26 at 8:58 a.m., identified a photographic review of R1's sacrum area showing a single wound pressure injury that was identified as a stage 3 pressure ulcer. The photograph reviewed showed a raw, red, open wound bed over the sacral and gluteal region with a fluid blister, extensive deep purple tissue discoloration, surrounding skin shearing, and widespread red mottling across both buttocks. R1’s record reviewed which included Point of Care documentation and progress notes between 7/13/26 through 7/28/26 did not include any documentation of rejection/refusal of care behaviors. During a phone interview on 8/24/26 at 9:45 a.m., family member (FM)-A stated R1 originally entered the facility with a pressure ulcer that healed quickly, which placed him at a high risk for developing another one. FM-A stated R1 developed an ugly wound on his buttocks because staff left him lying in bed and sitting in wet briefs for long periods. FM-A stated the hospital took a picture of the pressure ulcer upon admission and noted the injury could have been prevented. During an interview on 8/25/26 at 10:57 a.m., nursing assistant (NA)-A stated she worked with R1 frequently on the day shift and checked him for wet briefs every two hours. NA-A stated R1 rarely wanted to get out of bed, and if he did, he wanted to lie back down fifteen minutes later. NA-A stated R1 would claim he was dry when he was actually wet, requiring significant encouragement to even check him, and he was always wet when changed. NA-A stated R1 developed an open area on his tailbone in the middle of July, approximately two weeks before his hospital transfer, and she reported this out-of-the-normal finding directly to the nurse on duty.	20900		09/24/2026

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20900	Continued from page 15 During an interview on 8/25/26 at 2:23 p.m., registered nurse (RN) quality assurance director (QAD)-A, who was acting as the director of nursing (DON), verified R1 was bed-bound and dependent on staff for repositioning. QAD-A verified moisture-associated skin damage developed on R1's sacrum on 7/13/26 with no provider notification or treatment in place. QAD-A stated after R1’s pressure ulcer developed on 7/24/26, the facility had no assessment, monitoring, treatment, or provider notification in place. QAD-A confirmed there were no treatment orders or person-centered prevention interventions in place for the pressure injury. During a phone interview on 8/26/26 at 1:04 p.m., nurse practitioner (NP)-A stated she was not notified of R1's MASD on 7/13/26 or the development of pressure ulcer on 7/24/26 and confirmed that standard practice requires immediate provider notification of condition changes as well as daily skin assessments. NP-A stated the facility could have implemented standing house orders until a provider was able to look at it. NP-a further stated had been notified of the MASD, she would have ordered immediate treatments, including moisture barrier creams, strict turning schedules, and frequent incontinence checks to protect the skin and prevent it from breaking down into a pressure ulcer. Facility policy, Lifespark Pressure Injury Prevention Guidelines, dated 4/2026, identified it was the policy of the facility to implement evidence-based interventions to prevent avoidable pressure injuries and promote healing. The policy identified individualized interventions must address specific factors including moisture management, impaired mobility, nutritional deficits, staging, and wound characteristics. The guidelines directed staff to keep the skin clean and dry, manage incontinence by checking the resident every 2 hours, and protect the skin from excessive moisture with barrier products. The policy further identified a routine repositioning schedule of every two hours, using both side-lying and back positions when a resident was in bed and out of bed. The guidelines mandated that in the absence of prevention orders, the licensed nurse must utilize nursing judgment and notify the physician to obtain orders. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, should review all residents at risk for moisture-associated skin damage (MASD) and pressure ulcers to assure they are receiving the necessary treatment and services	20900		09/24/2026

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20900	Continued from page 16 to prevent skin breakdown, promote wound healing, and track wound characteristics and measurements. The Director of Nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care, person-centered prevention interventions, and services are implemented, and timely physician notification parameters are maintained. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		09/24/2026
20940	Rehab - Hydration CFR(s): MN Rule 4658.0525 Subp. 9 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R1) maintained acceptable parameters of hydration status to prevent renal complication, reviewed for quality of care. Findings include: R1’s Face sheet identified diagnoses of chronic kidney disease stage 4 (severe kidney damage where the organ can no longer filter waste properly), metabolic encephalopathy (brain dysfunction and confusion caused by severe chemical imbalances in the body), and nutritional deficiency (severe malnutrition from a lack of food and fluids). R1's order summary dated 5/13/26, identified an order for sodium bicarbonate 650 milligrams (mg)- (a medication used to balance high acid levels in the blood caused by kidney failure), two tablets twice a day. An additional order dated 6/15/26, directed staff to give ondansetron (an anti-nausea medication used to prevent throwing up) 4mg every 4 hours for nausea. R1’s mini nutrition progress note dated 5/14/26, identified R1 has no decrease in food intake or	20940	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. F692 1. Corrective Action for Identified Resident: R1 has discharged from the community. 2. Identification of Other Residents Potentially Affected: The interdisciplinary team will screen all current residents for nutrition high risk criteria, including kidney disease, fluid restrictions, diuretics, vomiting or diarrhea, recurrent low meal or fluid intake, or significant weight change. The nurse and dietitian will assess identified residents, establish individualized plans as appropriate, verify needed monitoring tasks in the EHR, and update care plans. Any acute concern will prompt same-day clinical assessment and practitioner contact.	09/24/2026

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20940	Continued from page 17 weight loss in the last 3 months. Further identified R1 was at risk for malnutrition. R1’s nutrition progress note dated 5/14/26 at 8:55 a.m., identified R1 was at risk for malnutrition related to a low assessment score. Risk factors included decreased mobility and severe illness. A malnutrition warning was completed and given to the floor nurse manager. The note stated staff would monitor weights and intakes. R1’s nutritional assessment dated 5/19/26, identified R1’s estimated fluid requirement was 2708 cubic centimeters (CC’s) per day and consumed greater than 2,000 cc of fluids per day. R1 explained appetite hasn’t been the best but was starting to improve. R1’s admission Minimum Data Set (MDS) assessment, dated 5/19/26, identified R1 had moderate cognitive impairment, required set up assist with eating and required a therapeutic diet. R1’s care area assessment (CAA) dated 5/19/26, identified a need for special diet or altered consistency which might not appeal to R1. R1’s care plan dated 5/19/26, identified a focus of potential for a nutritional problem related to a CSC (controlled carbohydrate) diet, metabolic encephalopathy, and CKD4 (stage 4 chronic kidney disease). Interventions dated 5/19/26 directed staff to provide and serve the diet as ordered. Staff were ordered to observe intake and record it every meal (type of “intake” was not specified between food and fluid or both). An additional focus dated 5/22/26 identified a risk for malnutrition and directed staff to provide oral supplements between meals as needed. R1’s progress note dated 5/31/26, identified R1 refused his sodium bicarbonate 650 mg tablet due to making him vomit. R1’s progress note dated 6/4/26 at 11:54 a.m., identified R1 vomited after taking his morning medication and blamed the sodium bicarbonate tablets. An additional note at 4:47 p.m. identified R1 refused the medication until he could see his provider. The provider was notified and wanted R1 to continue the medication. R1’s nurse practitioner (NP) visit note dated 6/8/26, identified R1 was seen for a follow-up. R1 reported vomiting at breakfast and lunch most days and felt it was related to the sodium bicarbonate pill (medication used to balance blood acid levels caused by kidney failure). New orders were received	20940	Continued from page 17 3. Systemic Changes: Polices related to Nutrition at Risk, Hydration, and Nutrition Management were reviewed and are appropriate as written. Nursing staff and the community dietitian were educated on accurate documentation of oral intake, completion of hydration-monitoring records, identification and communication of changes in intake, and appropriate follow-up when intake is inadequate or declining. Risks for malnutrition and dehydration will be assessed the Registered Dietitian upon admission and as indicated thereafter via the Nutritional Assessment in the EHR. Resident health history, risk factors, and changes in condition will be evaluated to determine the need for supplements, I&O monitoring, dietary interventions, or other individualized interventions. Meal and fluid intake will be monitored and documented after each meal to identify changes in intake patterns. Nursing, CNA, and Dietary staff will record intake prior to removal of consumed trays from the dining room or resident rooms. Signage/samples of fluid volume were laminated and distributed and audited randomly to ensure that they are available for reference. The Registered Dietitian will review identified at risk for malnutrition and dehydration residents with decreased meal or fluid intake on a weekly basis and make recommendations for additional interventions as indicated. 4. Monitoring Plan: Licensed staff will complete a random sample of 6 residents deemed at risk for malnutrition and/or dehydration per week for 4 weeks comparing documented fluid intake with observed intake. If determined in compliance QA team will reduce to weekly. Results will be reviewed by the QAPI Committee, which will evaluate compliance and determine whether additional monitoring or interventions are indicated. Education changes, and corrective action provided as indicated. Date Corrected: Woodbury Health Care Center will be in substantial compliance by 9.24.2026.	09/24/2026

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20940	Continued from page 18 to discontinue (stop) the morning dose of sodium bicarbonate due to vomiting, but to continue the afternoon dose. R1's progress note dated 6/10/26 at 1:28 p.m., identified R1 was sent to the hospital due to hypotension (dangerous low blood pressure). The note showed R1 was tired and sleepy, and staff pushed fluids before the transfer. R1's hospital after-visit summary (AVS) dated 6/10/26, identified R1's history of dialysis earlier in the year and a solitary (single functioning) kidney. R1 was seen for hypotension (dangerous low blood pressure) and stage 4 kidney disease. R1 had instructions to continue previously prescribed medications, including midodrine (a medication used to raise low blood pressure). The summary included an additional instruction to drink plenty of fluids to stay hydrated (keeping enough water in the body). In review of R1's medical record, although the hospital after visit instructed for R1 to drink plenty of fluids there was no indication the order was transcribed into the facility's physician order set, nor evident the care plan revised to include a fluid balance focus with goals and interventions. R1's progress note dated 6/11/26 at 4:00 p.m., identified an order for sodium bicarbonate 650 mg to be given in the evening. R1 refused to take this medication and stated that it made him sick and upset his stomach. R1's nurse practitioner (NP) recheck visit dated 6/15/26, identified R1 was seen for a hospital follow-up and was encouraged to ensure adequate oral hydration (drinking enough fluids). New orders were received to check a BMP (Basic Metabolic Panel, a blood test used to check kidney function and chemical balance) on 6/17/26. The note identified R3's Creatine baseline was 2.4-2.7. R1's progress note dated 6/22/26 at 10:14 a.m., identified ondansetron HCL 4mg tablet given due to R1 vomiting that morning. At 11:40 a.m., identified the medication was effective. R1's progress note dated 6/29/26 at 2:57 p.m., identified ondansetron 4mg was given for nausea and at 5:03 p.m., was noted to be effective. R1's progress note dated 6/30/26 at 1:03 a.m., identified ondansetron 4mg was given for nausea and at 3:11 a.m., was noted to be effective.	20940		09/24/2026

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20940	Continued from page 19 R1’s progress note dated 6/30/26 at 8:41 a.m., identified R1 reported feeling nauseous and received PRN (as-needed) ondansetron. The note further identified R1 was hungry but refused to eat solid foods, drinking only the broth from a can of soup and sipping on water. R1’s progress note dated 7/1/26, at 8:36 a.m., identified ondansetron 4mg was given for nausea and at 1:07 p.m., was noted to be effective. R1’s physician note dated 7/1/26 indicated R1’s oral mucosa is moist and intact and R1’s last creatine level (on 6/10/26) was 3.2 “which is a worsening”. R1’s progress note dated 7/16/26, at 9:41 a.m., identified ondansetron 4mg was given due to R1 being nauseated after breakfast nausea and at 2:01 p.m., was noted to be effective. R1’s progress note on 7/19/26, at 10:53 p.m., identified R1 had an episode of diarrhea shortly after eating food purchased by family and staff encouraged fluids. R1’s progress note dated 7/24/26 at 8:11 p.m., identified ondansetron 4mg was given for nausea and at 8:42 p.m., was noted to be effective. R1’s progress note dated 7/25/26 at 4:26 p.m., identified ondansetron 4mg was given for nausea and vomiting his lunch and at 8:39 p.m., was noted to be effective. In review of R1’s record between 6/10/26 through 7/26/26 identified although the 6/10/26 AVS directed increased fluid there was no indication of daily fluid intake tracking and no indication of completed assessments to determine R1’s fluid volume status including any fluid deficits and signs/symptoms of dehydration as a result of multiple episodes of nausea, vomiting, and reduced oral intake. R1’s progress note dated 7/27/26 at 5:33 p.m., identified a family member called and was very upset about R1’s confusion since the previous day. The family member demanded an immediate assessment. The note identified that the family member rejected a basic lab test and demanded R1 be sent to the hospital for a thorough assessment. Staff called the provider and received an order to send R1 to the emergency room per the family's request. R1’s progress note dated 7/28/26 at 5:39 p.m.,	20940		09/24/2026

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20940	Continued from page 20 identified R1 was sent to the emergency room on 7/27/26 and was treated for hypotension (dangerous low blood pressure) of 71/41, shock (a life-threatening drop in blood flow), hypoglycemia (dangerous low blood sugar) with a glucose level of 25, and acute on chronic renal failure (sudden kidney collapse). The note identified his creatinine (a waste product filtered by the kidneys) was at 8.39, indicating severe kidney failure. R1’s hospital notes dated 7/27/26, identified R1 arrived at the emergency room with a dangerous low blood pressure of 70/40. The notes showed R1 was severely acidotic with a blood pH of 7.18 (severe acid buildup in the blood) caused by worsening renal failure (kidney collapse). R1's creatinine had spiked from a baseline of 3.0 in June to an acute level of 8.0, and his GFR (kidney filtering rate) dropped to a level of 7. The notes further identified R1 was profoundly hypoglycemic (dangerously low blood sugar) because he had a multi-week history of not really eating or drinking and had refused most oral intake at his care center. The hospital provider concluded that this fluid and food starvation was the direct cause of his acute kidney collapse, low blood pressure, and low blood sugar. R1’s hospital discharge summary dated 7/30/26, identified R1 was admitted from a long-term care facility on 7/27/26 for hypotension (dangerous low blood pressure), severe acute kidney injury (sudden kidney collapse), and metabolic acidosis (severe acid buildup in the blood). The summary identified the family decided to transition R1 to comfort care on 7/28/26, and he passed away on 7/30/26. The final synopsis listed the cause of death as renal failure (kidney collapse) due to septic shock (a life-threatening infection response) and cardiogenic shock (heart pump failure). During a phone interview on 8/24/26 at 9:45 a.m., family member (FM)-A identified she called R1 on 7/27/26. R1 stated to FM-A that he had not consumed fluids for days. FM-A called the nursing station and requested laboratory tests to be completed. Facility staff refused and stated they would not perform labs until Wednesday. FM-A demanded that the facility call 911 to get R1 evaluated. During an interview on 8/25/26 at 10:57 a.m., nursing assistant (NA)-A stated that staff did not document fluid intake because there was designated place in the electronic record system to record it. NA-A stated throughout July R1 did not eat much, requiring significant encouragement to consume	20940		09/24/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20940	Continued from page 21 meals, and frequently threw up after eating. NA-A further stated that R1 was adamant about not wanting his food or fluids so the left-over trays were thrown away. NA-A confirmed she regularly reported these poor intakes and ongoing episodes of nausea and vomiting directly to the nurse on duty. During a phone interview on 8/25/26 at 2:52 p.m., licensed practical nurse (LPN)-A identified R1 ate only about one-quarter of his meals. LPN-A stated R1 had a lot of nausea and received ondansetron prn. LPN-A identified she was not sure if R1 had kidney disease. LPN-A further stated that if there was no task to document fluids in the electronic system, she was unable to monitor his fluid intake. During a phone interview on 8/25/26 at 3:05 p.m., registered nurse (RN)-A identified that R1 would not finish the small cup of water given with his medications and was not drinking much. RN-A stated that because fluid intake was not documented in the electronic system, staff had no way to review fluid logs or check if R1 met his hydration targets. RN-A identified he was unaware that R1 had a history of dialysis or kidney disease. RN-A further stated that when FM-A called on 7/27/26 regarding R1's confusion, he told her that routine blood work would take two days to process because of when the lab company visited the facility, leading to the decision to transfer R1 to the hospital. During an interview on 8/25/26 at 2:23 p.m., registered nurse (RN) quality assurance director (QAD)-A, who was acting as the director of nursing (DON), identified the facility did not have a policy for monitoring fluids. QAD-A stated that staff found no documentation regarding R1's fluid intake. QAD-A identified that the facility only monitors fluid intake if a doctor explicitly orders it. QAD-A confirmed that a resident who is care-planned to be monitored for a fluid deficit (severe dehydration) or overload due to kidney disease should have documentation of fluid intake so the provider can be notified of a change for ongoing direction. During an interview on 8/25/26 at 12:33 p.m., the certified food production manager (CFPM)-A stated R1 had renal failure and required monitoring for hypovolemia (low blood fluid levels). (CFPM)-A verified there were no medical orders or electronic point-of-care tasks put in place for fluid monitoring, noting that the facility only monitored fluids if a doctor specifically ordered it. (CFPM)-A confirmed that neither nursing nor social services ever submitted a formal dietary consult or notified the dietary department that R1 was persistently	20940		09/24/2026

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20940	Continued from page 22 nauseated, refused regular meals, or relied on outside liquids, and stated that the dietary department would have assessed R1 immediately had they been notified. During a phone interview on 8/26/26 at 1:04 p.m., nurse practitioner (NP)-A stated that nurses managing residents with kidney failure should actively monitor hydration and report signs of dehydration or decreased oral intake. The practitioner noted that had she been informed of ongoing nausea, she would have conducted an in-person assessment and ordered a basic metabolic panel. However, NP-A stated replacing fluids might not have changed the outcome because R1 had severe kidney disease. Facility policy for fluid monitoring was requested and not received. According to the National Kidney Foundation Acute Kidney Injury (AKI) Diseases and Conditions fact sheet. Acute kidney injury is sudden loss of kidney function that develops over a few hours to a few days. When it happens, waste products build up in the blood and the kidneys can no longer keep the body's fluid levels in balance. The effects are not limited to the kidneys the brain, heart, and lungs can also be affected. Older adults are at particular risk. One of the main causes of kidney injury is reduced blood flow to the kidneys. Loss of fluid from the body, including from prolonged diarrhea, is specifically identified as a trigger for this. Low blood pressure, heart failure, and overuse of common over-the-counter pain relievers are also listed as causes of reduced blood flow to the kidneys. Warning signs include putting out very little urine, swelling in the legs, ankles, or around the eyes, fatigue, shortness of breath, nausea, and confusion. Importantly, acute kidney injury sometimes produces no symptoms at all and is discovered only through testing. https://www.kidney.org/sites/default/files/acute_kidney_injury.pdfAccording to the Post-Acute and Long-Term Care Medical Association (PALTmed, formerly known as AMDA) — Dehydration and Fluid Maintenance in the Long-Term Care Setting, clinical practice guidance for post-acute and long-term care establishes that dehydration cannot be reliably identified through observation alone. Physical signs and symptoms are frequently vague or misleading, and staff should neither rely on their presence to confirm dehydration nor on their absence to rule it out. Because of this, the guidance directs staff and practitioners to recognize and report risk factors proactively — including diarrhea, diuretic use, and	20940		09/24/2026

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20940	Continued from page 23 medication side effects that interfere with eating and drinking. The guidance identifies a decrease in fluid intake, defined as less than 75% of food or fluid consumed at meals, as an indicator of increased risk of dehydration or the need for clinical evaluation. Additional risk factors include acute illness, dysphagia, fever, dietary restrictions such as thickened liquids, vomiting or diarrhea, and medications including ACE inhibitors and diuretics. Signs and symptoms warranting evaluation include change in mental status, change in activities of daily living, decreased urine output, postural hypotension, tachycardia, weakness, and weight loss. Intake monitoring is more accurate in residents who are completely dependent on staff for fluid intake and whose intake can therefore be reliably documented. Staff must routinely monitor all residents' intake of food and fluids, and noted changes in intake must be promptly investigated, including determining the cause of the change. Where a resident is partly or fully dependent on staff for feeding, staff must be available to assist and must know that the resident requires assistance with intake. Nursing assistants should be trained to systematically observe residents for early signs and symptoms of acute illness, and early detection of acute illness followed by objective estimation of hydration status is identified as key to preventing significant dehydration. Intravascular volume depletion can lead to hypotension, compensatory tachycardia, decreased tissue perfusion, and shock. https://paltmed.org/sites/default/files/2024-10/Dehydration%20CPG%2008092024.pd SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, should review all residents at risk for nutritional problems, weight loss, or dehydration to assure they are receiving the necessary treatment and services to manage caloric and fluid intake, promote hydration, and track necessary nutritional parameters. The Director of Nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented, electronic point-of-care fluid and food tracking tasks are completed accurately, and timely physician notification parameters are maintained. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for	20940		09/24/2026

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20940	Continued from page 24 further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20940		09/24/2026