STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbury Health Care Center	7012 Lake Road Woodbury, MN 55125

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview, and document review, the facility failed to ensure call lights were within reach and accessible for 1 of 3 residents (R1), who was dependent on staff for care. Findings include: R1's care plan revised 12/23/24, identified a focus that R1 had potential for/actual communication problem with difficulty expressing ideas, understanding others related to speech is clear. Intervention identified to ensure/provide a safe environment: Call light in reach, adequate low glare light, bed at appropriate height and wheels locked, and avoid isolation. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had diagnoses of encounter for palliative care, anxiety, depression, and chronic pain syndrome. R1's cognition was moderately impaired and required substantial to maximum assist for toileting hygiene, dressing and bed mobility. During an observation and interview on 4/28/25 at 12:15 p.m., R1's room on the third floor was the last room on the left at the end of the hallway furthest from the nursing station. R1 was heard right just outside her room yelling softly but urgently for help. R1 was lying in bed on her back with the head of the bed elevated approximately 30 degrees, behind R1's head was a pink body pillow where R1's soft touch call light was draped over the back of the pillow on R1's right side above her head and has a contracted left hand. R1 stated she needed help because her shoulders were hurting and was unable to reach her call light, and stated she did not know where it was. R1 was shown the call light, but she was unable to reach it and asked the button to be pushed for assistance. At 12:20 p.m., Nursing assistant (NA)-A and NA-B walked in the room and informed R1 they would get her up in the chair so she could eat lunch. At 12:22 p.m. Licensed practical nurse (LPN)-A administered R1's scheduled pain medications. NA-A, NA-B and LPN-A all stated that R1's call light was not within her reach and should be. NA-B stated she forgot to put the call light in place for R1 when she was last in R1's room about a half hour ago. NA-A and NA-B both stated R1 does use her call light to ask for help and the call light should be placed in reach of R1's right hand because her left hand was contracted. During an interview on 4/28/25 at 12:59 p.m., LPN-A indicated she was R1's nurse for the shift and that R1's call light should always be in reach. LPN-A stated R1 had anxiety and recently did not like being left alone. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/28/25 at 2:11 p.m., director of nursing (DON) stated it would be an expectation that all residents that are dependent on staff for ADL's that their call light should be within reach at all times. Facility policy, Accessible Call light, dated 5/1/25, identified the purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. 1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. 2. All residents will be educated on how to call for help by using the resident call system. 3. Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system. 4. Special accommodations will be identified on the resident's person-centered plan of care and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.) 5. Staff will ensure the call light is within reach of resident and secured, as needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and document review the facility failed to ensure Enhanced Barrier Precautions (EBP)- (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities,) were implemented or followed for management of a non-pressure skin wound to reduce the risk of infection to others for 1 of 1 resident (R1). Further the facility failed to implement hand hygiene for 1 of 1 resident (R1) observed during incontinence care and transfer. Findings included: R1's care plan revised 1/28/25, identified a focus that R1 had a disease/condition requiring precautions-wounds with drainage, history of Methicillin Resistant Staphylococcus Aureus (MRSA)-(caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections). Interventions dated 8/8/24, identified to bag and transport used linen according to facility protocol, preventing skin exposure or contamination, educate resident/family on appropriate use of antibiotics, stress importance of finishing all antibiotics, give antibiotic therapy as ordered, observe for and report and side effects to medical practitioner, isolation procedure according to the facility protocol, post sign on door, and contact isolation. Revision on 1/28/25, identified R1 required EBP precautions. The care plan does not identify to use EBP with high-risk activities or what the high-risk activities include. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1's cognition was moderately impaired and had diagnoses of peripheral vascular disease (PVD)- (a disease that involves reduced blood flow to limbs, often due to narrowed or blocked vessels, and can lead to symptoms like pain, numbness, and slow wound healing) and unspecified wound of lower left and right leg. R1's Treatment Administration Record (TAR) dated 4/2/25, identified R1's left leg wounds to clean wound with wound cleanser apply xeroform (petrolatum-based gauze dressing) to open areas only, apply ABD (highly absorbent pad used for wound care) then gauze wrap, change dressing every shift. R1's Medical Doctor (MD) note visit dated 4/14/25, identified R1's reason for a visit was a recheck. Assessment identified R1 had a history of wounds non-healing to bilateral lower extremities, history of recurrent cellulitis to left lower extremity requiring hospitalization /wound infection, history of MRSA bacteremia with open area on both legs, and bilateral venous stasis ulcers non-healing. History identified R1 was on hospice for PVD and open wounds. R1 has had at least 20 admissions related to this with multiple re-hospitalization due to cellulitis infected wounds and felt this was a noncurative condition. Amputation of R1's bilateral lower extremity was recommended but R1 refused. The hospital recommended hospice and feels that antibiotics would no longer be justified. Physical exam revealed R1's feet are cold with minimal edema noted on legs with venous stasis dermatitis- (a skin condition caused by poor circulation in the legs, leading to blood pooling and inflammation). Open areas on both legs with no dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/18/25 at 12:15 p.m., upon entrance to the left of R1's door was an orange paper sign taped to the wall. There were two STOP signs noted on the floor. Signage read: ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, changing linens, Providing Hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheotomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. The sign also had pictures of hand cleanser, gloves, and gown. There was no personal protective equipment (PPE) cart observed outside of R1's room. R1 was lying in bed and a dressing dated 4/28/25 was noted to R1's left lower leg. Nursing assistant (NA)-A and NA-B walked into R1's room without doing hand hygiene, and did not utilize masks or a gown. NA-A and NA-B applied gloves and performed incontinence care for R1. After removing R1's brief and providing peri-care, NA-A changed gloves without hand hygiene, applied a new pair of gloves. NA-B was assisting with rolling R1 in bed and kept her gloves on. NA-A and NA-B transferred R1 from the bed to her wheelchair using a full body mechanical lift. NA-A removed her gloves without doing hand hygiene and wheeled R1 to the dining room for lunch and placed a protective clothing covering on R1's chest. NA-B removed gloves and performed hand hygiene and carried R1's covered lunch tray that had been sitting on her bedside table to the dining room and heated her food up in the microwave. During an interview at 12:26 p.m. NA-A and NA-B stated they were not aware that they needed to use EBP during personal cares for R1. Both stated when a resident was supposed to be on EBP precautions the DON would put a PPE cart outside of the resident's room. Both verified the signage was outside of R1's door and no PPE cart was observed. Both staff stated R1 had a wound on her left lower leg. NA-A and NA-B stated all their PPE was disposable and would just dispose of the PPE in the resident's garbage can in the resident's room. NA-A stated she did not wash her hands after changing from soiled to clean gloves or upon entering and exiting the room. NA-B stated she did not perform hand hygiene upon entrance to the room. On 4/28/25 at 12:59 p.m., licensed practical nurse (LPN)-A stated she was R1's nurse for the shift and staff should follow EBP precautions for all personal care, including toileting, incontinence care, and transfers, due to R1's wounds and MRSA history. LPN-A was unaware that a PPE cart was not available outside R1's room. She also emphasized that hand hygiene should be practiced upon entering and exiting the room, as well as between dirty and clean glove changes. During an interview on 4/28/25 at 2:11 p.m., director of nursing (DON stated it would be an expectation for all staff to follow facility policy and procedure of EBP and hand hygiene. DON verified R1 was on EBP precautions due to chronic venous wounds and history of MRSA, this would include to use mask, gown and gloves with any personal cares to include toileting/incontinence care. DPON further stated hand hygiene upon entrance and exit of resident room, along with hand hygiene between glove changes would be the expectation to help prevent the risk of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy PPE selection and Use, reviewed 9/2023, identified Purpose: Improve personal safety with the appropriate use of Personal Protective Equipment. GUIDELINE: Personal Protective Equipment (PPE) is clothing or equipment worn by an employee for protection against infectious materials (OSHA). Enhanced barrier precautions used for any resident with an infection or colonization of a novel or MDRO when contact precautions do not apply. These precautions are intended for long term use and Isolation is NOT required. Enhanced Barrier Precautions may apply to wounds or indwelling medical devices (central line, urinary catheter, feeding tube, tracheotomy) regardless of MDRO colonization. These precautions are used during high contact resident care activities such as dressing, bathing, transfers, hygiene, incontinence care, device or wound care. Facility policy, Hand Hygiene, revised 7/21, identified Purpose: Proper hand washing techniques should be used to protect the spread of infection. Cleaning your hands reduces the spread of potentially deadly germs to the resident and reduces the risk of healthcare provider colonization or infection caused by germs acquired from the resident. Hand hygiene may occur multiple times during a single care episode. Use alcohol based hand sanitizer immediately before touching a patient before moving from a soiled body site to a clean body site on same resident/patient, after touching a resident/patient or the resident's/patient's immediate environment, after contact with blood, body fluids or contaminated surfaces and immediately before putting on gloves and after glove removal.