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	12/02/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to accurately transcribe a medication order correctly for Bumex (diuretic medication used to remove fluid) for 1 of 1 resident (R1) which resulted in an 18-pound (lb.) weight loss in 12 days, critical labs, vomiting and a hospitalization. In addition, the facility had two additional medication errors and failed to implement appropriate corrective actions to prevent the significant medication error for R1. The facility failure resulted in an immediate jeopardy (IJ) for R1.The IJ began on 11/07/25, when R1 was ordered Bumex (diuretic) 2 milligrams (mg) by mouth (po) QD (daily) x three days. The order was transcribed as Bumex 2 mg po TID (three times daily) with no stop date indicated. As a result, R1 received (36) 2 mg doses from 11/7/25 to 11/18/25 versus the 3 doses he should have been administered. R1 was admitted to the hospital with acute kidney injury and infection on 11/18/25. The administrator and director of nursing (DON) were notified of the IJ on 11/26/25 at 3:05 p.m. The IJ was removed on 11/28/25, at 1:45 p.m. , but non-compliance remained at the lower scope and severity of level D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact had cellulitis of left lower limb, atrial fibrillation, renal insufficiency (kidneys are not functioning as well as they should, leading to waste products and fluid buildup in the body) and cardiomyopathy (heart disease that affects the heart muscle's ability to pump blood efficiently). The MDS also indicated he was frequently incontinent of bladder, required partial assist with toileting had one diabetic foot ulcer with infection and received an antibiotic medication. The MDS further indicated his weight was 179 lbs. and no weight loss or unknown weight loss.R1's Care Plan dated 11/05/25, indicated he had renal failure/insufficiency related to chronic kidney disease and directed staff to provide fluids as ordered, give medications as ordered by medical practitioner, observe for changes in mental status: lethargy, somnolence, fatigue tremors and seizures. Observe for signs of fluid loss or fluid overload, observe lab reports of electrolytes and report to medical practitioner.R1's Medical Diagnosis List undated, indicated he had chronic kidney disease and failure and Type II Diabetes. On 11/6/25, R1 was order Bumex (diuretic) 2mg po QD (daily) x three days. The order was transcribed as Bumex 2mg po TID (three times daily) with no stop date indicated. As a result, R1 received (36) 2mg doses from 11/7/25 to 11/18/25 versus the 3 doses he should have been administered.R1's Lab results indicated the following: On 11/18/25:BUN- 99 H (high) (8-23) (evaluates kidney function.)Creatinine 3.4 H (0.67-1.7) (checks kidney function.)GFR 19 L (low) >60 (measures how well kidneys are filtering waste from your blood.) WBC 13.33 H (4.0 to 0.11) (shows if you have an infection.) Weight on 11/6/25 was 182.2, 11/18/25 was 163.4, a loss of 18. 8 pounds. Additionally, between 11/6-11/18, a weight was to be recorded weekly and was missed the week of 11/10/25.Progress Note dated 11/17/25 at 11:55 p.m., indicated R1 reported not feeling well during day shift and evening shift, vital signs stable on this shift, but patient refused to go to the hospital to be evaluated. MD (medical doctor) notified and ordered BMP (basic metabolic panel, CBC (complete blood count) and thyroid stimulating hormone (TSH) to be drawn tomorrow. Progress notes on 11/18/25 at 2:38 p.m., indicated MD called with lab results and to talk to family to see if they want him transferred to the emergency department (ED) for further evaluation and treatment. Labs indicate resident is dehydrated, this writer talked to family resident will be transferred to hospital and 911 called all paperwork sent with emergency medical services (EMS). Family would like to hold the bed. R1's Emergency Department Encounter dated 11/18/2025 at 4:06 p.m., indicated he presented to the ED department by emergency medical services (EMS) for evaluation of generalized weakness. The transitional care unit (TCU) he was at had been administering 2 mg of Bumex TID since 11/07 or 11/10 (staff unsure) instead of how it was prescribed which was 2mg of Bumex daily for three days. The ED note indicated the final Impression was Acute Kidney Injury (AKI) superimposed on CKD (chronic kidney disease).R1's Hospital admission Encounter dated 11/18/25, indicated noted to have miscommunication regarding his Bumex dose and had been taking TID (since 11/6) instead of daily x 3 days. Holding Bumex this admission, renal function gradually improving, continue oral bicarbonate and received IV fluids after angiogram yesterday, has colitis (C.diff)(clostridioides difficile bacterium that causes an infection of the colon, the longest part of the large intestine) developed abdominal pain, diarrhea and elevated WBC (white blood cell count) this stay. Placed on oral Vancomycin (used to treat serious infections) QID (four times a day) (starting 11/20) and probiotic. In addition, has Chronic left foot wound. Weight listed was 165 lbs. During interview on 11/25/25 at 10:21 a.m., director of nursing (DON) stated the provider wrote a written