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	07/24/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a self administration of medications (SAM) was completed to allow residents to safely administer their own medications for 1 of 1 resident (R68) observed with a medication at the bedside. R68's Medical Diagnosis form indicated the following diagnoses: acute and chronic respiratory failure with hypoxia, severe persistent asthma, chronic obstructive pulmonary disease with acute exacerbation, and emphysema.R68's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition, and had shortness of breath with exertion when sitting at rest, and when lying flat. R68's care plan dated 4/3/25 indicated R68 could not self-administer medications and nebulizers, and the facility was to administer medications as resident was not safe to independently administer medications at this time. Additionally, a SAM was to be completed quarterly and as needed. R68's physician orders form indicated the following orders:3/23/25, and discontinued on 7/22/25, Albuterol Sulfate HFA inhalation aerosol solution 108 (90 Base) microgram (MCG)/ACT inhaler inhale 1 puff orally every 4 hours as needed for wheezing. Inhale 1-2 puffs into the lungs to be administered by the clinician.7/22/25, Albuterol Sulfate HFA inhalation aerosol solution 108 (90 base) mcg/ACT 2 puffs inhale orally every 4 hours as needed for wheezing to be administered by the clinician. R68's medication administration record (MAR) and treatment administration record (TAR) dated July 2025, lacked information R68 utilized as needed Albuterol. R68's MAR and TAR lacked information R68 could SAM her Albuterol metered dose inhaler (MDI).R68's Self Administration of Nebulizers Evaluation form dated 4/3/25, indicated R68 had a physician's order to self-administer nebulizers and could be left along during administration of nebulizer treatment. The form lacked information whether R68 could self-administer her Albuterol MDI.R68's nursing progress notes were reviewed and lacked information R68 could SAM her Albuterol MDI. During observation on 7/21/25 at 1:25 p. m., R68 had an Albuterol inhaler on the bedside table in her room and stated she used the inhaler. During observation on 7/23/25 at 7:14 a.m., R68 had an inhaler on her bedside table.During observation on 7/23/25 at 8:22 a.m., an unknown staff person entered R68's room and delivered her meal and left the room.During observation on 7/23/25 at 8:25 a.m., nursing assistant (NA)-A entered R68's room and placed a packet of butter on the bedside table and left to get R68 a spoon. R68 had the albuterol inhaler with an open date of 12/27 written on the label. At 8:26 a.m., NA-A entered the room to assist R68 with her bed and left the room. During interview and observation on 7/23/25 at 9:10 a.m., licensed practical nurse (LPN)-A entered R68's room and moved R68's meal tray off the bedside table and started R68's nebulizer. At 9:11 a.m., LPN-A left the room with the meal tray. LPN-A stated a few residents can have medications at the bedside and stated those residents had an order to do so and they also have an assessment to make sure they are alert and oriented and further stated for inhalers to be self-administered, staff had to make sure residents understood to how to breathe into the inhaler and take two puffs and stated the technique differed from a nebulizer. LPN-A viewed R68's orders for her Albuterol inhaler and verified the medication was supposed to be administered by the clinician and verified R68's Albuterol inhaler was located on her bedside table and stated that was something that could be followed up on and stated there needed to be an order and stated he looked to the MAR to know if a resident could SAM. During interview on 7/23/25 at 9:24 a.m., LPN-B viewed R68's orders in the paper chart and stated R68 had an order to SAM nebulizers but did not have an order to SAM the Albuterol MDI. During interview on 7/23/25 at 9:28 a.m. with registered nurse (RN)-B and LPN-B, RN-B viewed R68's paper chart and both RN-B and LPN-B stated R68 should have a SAM assessment for the Albuterol MDI in addition to her assessment for nebulizers. LPN-B stated if a resident had a nebulizer the nurse had to assess if the resident could keep the mask on and if a resident had an MDI the nurse had to educate the resident on how many puffs they can take and watch them and document if they are able to know the frequency and both RN-B and LPN-B verified R68 did not have a SAM assessment for an MDI, and did not have an order to SAM the Albuterol MDI.During interview on 7/23/25 at 10:41 a.m., the director of nursing (DON) stated if a resident wanted to self-administer their medications, a SAM assessment would be completed, and an order would be obtained from the provider and further stated she expected MDIs would not be kept at the bedside unless it was determined the resident was safe to SAM. A policy, Medication Self Administration Safety Screen and/or Self Administration dated 9/2023, indicated the Medication Self Administration Safety Screen and/or the Self Administration of Nebulizer's Evaluation is only completed if the resident requests to do their own medications or some of their own medications such as inhalers, eye drops

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure a resident's wishes for resuscitation were accurately documented in all areas the medical record for 1 of 22 residents (R87) reviewed for advanced directives. R87's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition and diagnoses of [NAME]-Danlos Syndrome, signs and symptoms involving cognitive function and awareness, and Chronic Obstructive Pulmonary Disease (COPD). It further indicated R87 required supervision with activities of daily living (ADL) and was independent with mobility. R87's face sheet/banner in Point Click Care (computer system for documentation) indicated Do Not Resuscitate (DNR). R87's physician's orders indicated DNR. R87's Physician's Order for Life Sustaining Treatment (POLST) dated [DATE], indicated Cardiopulmonary Resuscitation (CPR) and DNR. During interview on [DATE] at 6:22 p.m., R87 stated she did not want life saving measures and there comes a point in your life where you don't want to be filled with junk anymore so when your time comes, it comes. During interview on [DATE] 6:30 p.m., registered nurse (RN)-A stated if a resident was found unresponsive, the first place they would look for their code status would be on the POLST. If the POLST indicated both CPR and DNR, they would error on the said of caution and perform CPR. RN-A further stated if a nurse made an error when filling out the POLST, they should get a new one and start over because it was a very important document. During interview on [DATE] at 7:05 p.m., licensed practical nurse (LPN)-C stated if a resident was found unresponsive, the first place they would look for their code status would be on the POLST. If the POLST indicated CPR and DNR or there was a discrepancy, they would get clarification from the nurse manager on what should be done. LPN-C further stated if they made an error while filling out a residents POLST, they would get a new one and have the resident/resident representative re-sign it. During interview on [DATE] at 7:55 p.m., LPN-D stated if a resident was found unresponsive, the first place they would go to check their code status was the POLST. The POLST shouldn't indicate CPR and DNR because a physician goes over it, however if it did indicate both options, they would clarify it with the resident or their responsible party in order to determine what to do next. During interview on [DATE] at 7:52 p.m., LPN-E stated if a resident was found unresponsive, the first place they would look for their code status would be on the POLST. If there was a discrepancy, they would get clarification from the nurse manager/supervisor on what to do. During interview on [DATE] at 11:45 a.m., the nurse manager RN-C stated if a resident became unresponsive, the first place they would look to find their code status would be on the face sheet/banner in PCC because if they are at the cart, it's the closest place to look. RN-C would also encourage the nurses to look at the residents POLST in order to compare the face sheet/banner to the POLST. If the POLST indicated CPR and DNR, then the nurse should compare it to the banner in PCC. If there was a discrepancy or staff had a question, they should clarify it with the nurse manager/supervisor in order to know how to proceed. During interview on [DATE] at 12:34 p.m., the director of nursing (DON) stated if a resident became unresponsive, the first place nurses would look to find their code status would be on their POLST. There was also an order in PCC with a banner/ribbon that should match. If there was a discrepancy, they should look at dates to see which one was the most recent. They should also do a quick comparison. If family was easily reachable, the nurses could contact them as well. If the POLST indicated both CPR and DNR, the nurse should compare it to the face sheet/banner in PCC. If the nurse makes an error on POLST, they should get a new POLST. This was important because it leaves it open to too much interpretation when we get messy like that.The facility policy regarding advanced directives dated 12/2018, indicated when the need for resuscitation occurs, the physician order status, and/or (CPR) Resuscitate/Do not Resuscitate decision in Part 2 of the Health Care Directive and/or Part A of the POLST will be followed and then the physician will be notified as soon as possible.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide routine care conferences to allow for resident/ family participation and interdisciplinary review, and update, if necessary, of the care plan for 1 of 1 resident (R50) reviewed for care conferences. Findings include:R 50's quarterly Minimum Data Set (MDS) dated [DATE] severely cognitively impaired, unable to communicate clearly, and understand others. R50 had the following diagnoses: major depressive disorder, Alzheimer's, unspecified psychosis not due to a substance or known physiological condition, unspecified dementia, psychotic disturbance, mood disturbance, and anxiety.R50's electronic medical record (EMR) indicated R50 had a care conference on 6/24/25, EMR indicated the last documented care conference for R50 was 10/7/24.During an interview on 7/21/25 at 6:28 p. m., R50's family member (FM)-A stated the facility were doing care conferences quarterly then it changed. FM-A stated it was explained to them the social worker left the facility, so no care conferences were offered. FM-A wanted to be included in care conferences and give input for care plan of R50.During an interview on 7/24/25 at 11:48 a.m., LPN manager (LPN)-A stated the care conferences and care plan review were held quarterly, annually, if changes occur, staff or family request. The expectation was informing resident, family, dietary, physical, occupational and speech therapy, speech, social services, community life, nurses, doctors, director of nurses and executive director to attend care conference.During an interview on 7/24/25 at 12:16 p. m., the director of social services (SS)-A stated the expectations for care conferences and care plan review were held quarterly, annually, and if requested. The care conference and care plan were correlated with the MDS. The expectation was informing resident, family, dietary, physical, occupational and speech therapy, , social services, community life, nurses, doctors, director of nurses and executive director to attend care conference. The importance of care conferences was to collaborate across disciplines, provide comprehensive assessments, meet the psychosocial needs of residents and families and provide resources. During an interview on 7/24/25 at 3:14 p.m., the director of nurses (DON)-A stated the process for care conferences were to be done upon admit, quarterly and annually. The care plans and care conferences are assessed in the same time frame. The expectations for care conferences were to collaborate with family and resident and address any concerns. The family, resident and members of the interdisciplinary team (IDT) were informed of the time and date of care conference. The importance and individualized care plans are through care conferences, the collaboration with family and resident learn about them, how they grow and meet their needs at their level.A facility policy titled Care Conferences stated the care conference guidelines indicated the IDT would review and update after: *Initial: Complete Care Conference after admission MDS, CAAs, care plan was completed Quarterly Discharge Planning Change in condition As needed for any resident and/or family request

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, observation, and document review, the facility failed to ensure symptoms of constipation were acted upon and assessed to determine what, if any interventions were needed to promote appropriate bowel management for 1 of 1 resident (R4). Findings include:R4's Optional State Assessment (OSA) dated 7/8/25, indicated R4 did not reject care, required extensive assistance with bed mobility and toilet use, and was not on a urinary or bowel toileting program.R4's Medical Diagnosis form indicated the following diagnoses: hemiplegia (paralysis of one side of the body) affecting the left nondominant side, diabetes mellitus (DM), muscle weakness, chronic idiopathic (without a known cause) constipation.R4's care plan dated 10/3/24 indicated R4 had a self care deficit due to a stroke and required substantial to maximal assist of one for personal hygiene. R4's care plan dated 7/17/25 indicated R4 refused to get out of bed due to refusing the mechanical lift. R4's care plan dated 10/14/24, indicated R4 had frequent incontinence of bowel and bladder and interventions indicated to record bowel movements daily and used a bed pan and urinal. R4's care plan dated 7/8/25, indicated R4 had a nutrition problem due to diagnoses that included constipation. R4's physician's orders form indicated the following orders: 4/24/25, senna-docusate sodium (stool softener) oral tablet 8.6-50 milligram (MG) tablet, give one tablet twice a day.4/24/25, bisacodyl rectal suppository (a laxative) 10 mg, insert 10 mg rectally every 72 hours as needed for constipation.R4's medication administration record (MAR) and treatment administration record (TAR) dated June 2025, indicated R4 received senna-docusate sodium twice daily. Further, R4 did not utilize any PRN bisacodyl medication. R4's MAR and TAR dated July 2025, and saved 7/24/25 at 7:08 a.m., indicated R4 received senna-docusate sodium twice daily. Further, R4 did not utilize any PRN bisacodyl medication. R4's Task form titled, Bowel Continence & BM, dated 5/26/25, to 7/24/25, indicated the following:On 6/13/25 at 2:22 p.m., R4 had a large bowel movement. No further bowel movements were documented until 6/18/25 at 7:42 p.m., when R4 had a large bowel movement. On 6/18/25 at 7:42 p.m., R4 had a large bowel movement. No further bowel movements were documented until 6/22/25 at 9:49 p.m., when R4 had a medium bowel movement.On 6/23/25 at 7:40 p.m., R4 had a large bowel movement. No further bowel movements were documented until 6/27/25 at 5:55 a.m., when R4 had a medium bowel movement. On 7/1/25 at 8:16 p.m., R4 had a large bowel movement. No further bowel movements were documented until 7/6/25 at 2:41 p.m., when R4 had a large bowel movement. On 7/8/25 at 12:34 p.m., R4 had a large bowel movement. No further bowel movements were documented until 7/14/25 at 2:29 p.m., when R4 had a large bowel movement.On 7/17/25 at 9:26 p.m., R4 had a medium bowel movement. No further bowel movements were documented until 7/21/25 at 9:45 p.m., when R4 had a small bowel movement. R4's nursing progress notes were reviewed from 5/26/25, to 7/23/25, and lacked information R4 was administered as needed bisacodyl if R4 had no bowel movement for 72 hours. Further, progress notes lacked physician notification during days R4 went longer than 72 hours without a bowel movement. Progress notes lacked information R4 was going longer than 72 hours without having a bowel movement. R4's Comprehensive Nursing Data Collection form dated 7/2/25, indicated R4 was alert and oriented to person, place, time, and situation, had frequent bladder incontinence, and was continent of bowels. Further, R4's bowel sounds were present and active, had a soft and rounded abdomen, and under a heading, Date of last BM indicated, see CNA task. During interview and observation on 7/21/25 between 12:44 p.m., and 12:51 p.m., R4 was in his bed and stated he hadn't gone to the bathroom in 5 days and stated he felt some movement, but the stool did not want to come and added this was an everyday concern. R4 stated staff provided a bedpan and stated he asked about Miralax (a medication to treat constipation) which he stated sometimes helped and prune juice and added it was very uncomfortable. R4 stated his normal pattern was every other day not every 5 days. During interview on 7/24/25 at 9:44 a.m., licensed practical nurse (LPN)-B stated refusals were documented in a progress note and staff documented bowel movements in the Tasks form where the nursing assistants (NA) document the size of the bowel movement and the NA's report if a resident does not have a bowel movement in a while and can additionally look in the dashboard. LPN-B stated if a resident had no bowel movement in three days, they provided prune juice and further stated R4 complained of constipation a while ago. LPN-B stated she expected staff to administer as needed (PRN) medications and complete a bowel assessment and verified R4 did not have PRN medications administered in June and added R4 had senna-docusate sodium, but it was not working and verified R4 was not on any additional medications for constipation. LPN-B viewed the aide documentation and stated they would administer a suppository and if the suppository wasn't effective

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assess trauma history and identify potential triggers for 1 of 1 residents (R8) with post-traumatic stress disorder (PTSD). Findings include:R8's quarterly Minimum Data Set, dated [DATE], indicated R8 was cognitively intact and had diagnoses of anxiety, depression and PTSD. R8's trauma screening assessment dated [DATE], indicated R8 had experienced a traumatic event, and a referral was made for a counselor or therapist. The assessment lacked information of the traumatic event and lacked assessment of anything that may trigger R8's trauma experience.R8's care plan dated 11/7/24, indicated R8 had experienced trauma/PTSD and referred staff to Associated Clinic of Psychology (ACP)notes. R8's care plan lacked identification of triggers for R8's PTSD. Interventions included therapy referral if indicated, chaplain visits as requested, consistent staffing if able, validate feelings and approach calmly. R8's ACP progress note dated 3/25/25, indicated R8 received ACP services for persistent depressive disorder and PTSD. ACP indicated continued services were required to maintain and improve R8's functioning as emotional symptoms had affected R8's functioning. When interviewed on 7/21/25 at 12:23 p.m. , R8 stated staff often did not knock when entering the room, even into the bathroom when I am naked! R8 further stated she did not like when people surprised her or came up behind her. I have PTSD and just don't like surprises. R8 was not sure if staff ever talked with her about PTSD or if staff were even aware of it. When interviewed on 7/23/25 at 9:28 a.m., nursing assistant (NA)-B stated R8 required assist of one for transferring and toileting. NA-B stated R8 was not sure if R9 had PTSD and wasn't aware of any triggers that would upset R8. NA-B reviewed their tablet and verified there was nothing about PTSD on their task sheet. The only thing was on there was to monitor for depression. When interviewed on 7/23/25 at 9:50 a.m., registered nurse (RN)-D was not sure if R8 had PTSD. RN-D stated R8 had some behavior monitoring in place for depression and side effects of her medications. RN-D was not aware of any possible triggers or behaviors for R8. RN-D verified R8's care plan mentioned the diagnosis of PTSD, however did inform staff of any triggers for R8 and further stated that was where that information should be, When interviewed on 7/23/25 at 12:12 p.m., the Director of Social Services (DSS) stated a trauma assessment was completed upon admission and as needed during the resident stay. DSS stated the assessment should identify PTDS and assess for triggers and what kind of support was helpful. This information then put in the care plan. DSS had recently started this job and has just become aware of R8's PTSD and was not aware of any triggers as it had not been discussed. DSS would expect R8's assessment to include any triggers for R8's PTSD as well as the care plan. A facility policy titled Trauma Informed Care dated 2025, directed staff to identify a residents history of trauma including potential triggers or stressors that may prompt recall of a traumatic event. The identified triggers will have trigger-specific interventions in place to decrease effects of the trigger and ensure the information was included in the plan of care.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:2Number of residents cited:2Findings include:R11's quarterly Minimum Data Set (MDS) dated [DATE], indicated R11 was cognitively intact and had diagnoses of anxiety and depression. R11's care plan revised 12/15/24, indicated R11 had a psychosocial well-being problem related to depression and anxiety. Interventions included to encourage R11 to verbalize feelings, perceptions and fears and help identify precipitating factors of stressors.R11's medical record lacked indication follow up was completed after a behavioral outburst by R105. R105's admission MDS dated [DATE], indicated R105 was cognitively intact and had diagnoses of adjustment disorder with mixed disturbances and conduct and heart failure. R105's nursing progress note dated 6/17/25 at 8:48 p.m., indicated R105 had loud and disruptive behaviors for over 4 hours. The note indicated other residents were visibly upset from the behavior. A message was left for the nurse manager. R105's nursing progress note dated 7/19/25 at 9:51 p.m., indicated R105 was yelling and cursing at staff. R105 was disrupting other residents rest time.R105's nursing progress note dated 7/20/25 at 9:09 p.m., indicated after R105 was assisted into the wheelchair the resident became disruptive and was yelling and cursing at staff. R105 was so disruptive, other residents started to complain. The nurse in charge was notified and advised to call 911 due to uncontrollable behavior. Police and ambulance staff arrived with resident refusing to go to hospital. After, R105 calmed down and staff assisted back to bed. R105's care plan revised 5/8/25, indicated R105 exhibited angry outbursts, yelling and throws items. Interventions included a behavioral health consult. Triggers include needs not being met upon request, especially when brief wet. Furthermore, R105 had potential for communication problem with difficulty understanding verbal content related to mood and anxiety. Interventions included provide a safe environment, anticipate needs, assist with incontinent cares timely, and to observe effectiveness of communication strategies. When interviewed on 7/21/25 at 4:56 p.m., R11 stated R105 was always yelling and screaming. R11 stated yesterday I was afraid of her. R105 was swearing and yelling so much, it was scary, and I was afraid of what was going to happen. Suddenly, the police were here. R11 didn't know what had happened and hoped it didn't happen again. When interviewed on 7/23/25 at 12:35 p.m., nursing assistant (NA)-B stated R105 yelled out when she wanted help. NA-B stated she had heard about the police being notified however was not aware of why. NA further stated some of the residents down the hall had talked about the police being here when R105 was upset, but they didn't go into details. When interviewed on 7/23/25 at 12:39 p.m., registered nurse (RN)-E stated R105 would scream at the top of her lungs and sometimes came out of her room and would scream in the hallway. RN-E stated it was scary when R105 would do that as she was intimidating. RN-E was aware of 911 was called due to R105's behavior when it was out of control and verified R105's behavior was very scary for other residents. RN-E stated residents down the hall had voiced concerns about it. When interviewed on 7/23/25 at 1:45 p.m., RN-F stated any resident incidents were talked about during morning meeting. RN-F attempted to talk to R105, however R105 did not want to talk and wanted to talk later. RN-F had not returned to discuss the situation. RN-F further stated all they really knew about the situation was what was written in the progress note. No follow up had occurred with R105, R11 or other residents. When interviewed on 7/23/25 at 1:57 p.m., the Director of Social Services (DSS) stated they reviewed the 72-hour report on Mondays to review any behavior incidents from the weekend. DSS was aware of R105's from the report and had read about it in the progress notes. DSS had followed up with R8 who voiced concerns during an assessment, however had not followed up with any other residents to determine if there was any support needed after the police incident and was not aware of R11's feelings of the situation. A facility document titled Social Worker- Senior Living dated 6/6/22, indicated the social services department was responsible for providing each residents emotional and psychological needs from admission to discharge.

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	07/24/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and document review, the facility failed to ensure food items were disposed of when needed and were properly stored, labeled, and dated. This had potential to affect all residents, staff, and visitors who consumed food from the main kitchen,and dining refrigerators.Findings include:During the initial kitchen tour on 7/21/25 at 12:03 p.m., the large refrigerator in the hallway across the main kitchen had an opened package of tortilla shells which were not secured closed and not labeled with an opened date. CD and kitchen supervisor (KS)-D stated the kitchen served tacos over the weekend. The large freezer in the hallway across from the main kitchen had meat in an unlabeled freezer bag with a zip lock. KS-D stated the bag contained cooked ribs they used the day prior. The freezer contained meat in clear, tight-sealed packaging and did not contain a label. KS-D stated the meat was pork shoulder which was delivered to the kitchen and expected the label to be cut off from the original box and placed on the meat if the box got damaged.During continued tour with the CD, the second-floor refrigerator in the dining room down the left hallway had a cup from Chick-Fil-A with a sticky note which contained a room number and no date. CD stated nursing may know more about the contents, and they did not let food or items like that stay in the refrigerator longer than a day. CD stated the servers go through the dining refrigerators every shift.During observation and interview on 7/21/25 at 12:49 p.m., KS-D expected items in the refrigerator to be labeled and dated and stated staff checked the refrigerators daily. The third-floor refrigerator in the dining room closest to the elevators contained a fast-food package with a receipt which read 7/7/25. Another type of to-go box was labeled 6/15/25. Another food container was labeled with a resident name, but the date was not seen before KS-D removed the item. The freezer contained at least two freezer meals, such as mashed potatoes and cheddar broccoli freezer meals, from a resident with use by dates of 3/2/24 and February 2024. KS-D removed other items from the freezer and stated they had dates of 2024.During observation and interview on 7/21/25 at 1:22 p.m., the second-floor refrigerator in the dining room closest to the elevators had two packages of fully cooked cheddar smoked sausages. Nursing assistant (NA)-B verified the packages did not have a resident name and a use by date of 7/11/25.During interview on 7/23/25 at 12:35 p.m., dietary aide (DA)-B stated the culinary staff who served on the floor were responsible for checking the refrigerators for unlabeled or outdated items.During observation and interview on 7/23/25 at 12:41 p.m., KS-E stated resident food items were thrown away if expired or past use by date. In the large refrigerator in the hallway across from the main kitchen, there was a pan with meat and liquid which did not have a date or label. KS-E stated the meat was prepped the day prior to marinate and was going to be used for tonight's dinner. Ground beef was in its original packaging and box and had red liquid visible inside the bottom part of the tight-sealed packaging. KS-E stated the ground beef was raw and was going to be used for tomorrow night and Saturday lunch. KS-E stated the ground beef was delivered fresh on 7/17/25 and verified the package had a use by or freeze by date of 7/21/25.During follow-up interview on 7/24/25 at 9:53 a.m., NA-B stated staff were supposed to label and date resident or other food items placed in the dining room refrigerators or freezers. NA-B stated both dietary and nursing staff were responsible to ensure food was labeled and disposed of when needed.During interview on 7/24/25 at 1:17 p.m., cook (CK)-A stated food should be closed and wrapped and labeled with an opened date. CK-A stated how long the kitchen kept food depended on what the item was.During interview on 7/24/25 at 1:37 p.m., the CD expected staff to wrap, cover, label, and date used food at the end of the shift to keep the quality of the item and ensure items were not old or past the date it should be used. CD expected food prepped ahead of time to be dated when it was prepared and then used in a day and a half. CD stated nursing was responsible for resident food items in the refrigerator. CD stated dietary staff did not use the microwaves in the resident dining areas and were going to start taking the responsibility to clean them.During interview on 7/24/25 at 3:36 p.m., the director of nursing (DON) stated staff who placed food in the refrigerator or freezer or who served food should label and date food to ensure they served safe food. Lifespark Senior Living and Senior Care Communities Food Brought in to Residents from Outside for Storage and Consumption policy dated 2/2019, indicated staff checked any food or beverage brought into the facility for resident consumption. Food or beverages brought in were labeled with the resident's name, room number, and dated by nursing with the current date the item(s) was brought to the facility for storage. The policy directed nursing staff to monitor resident's room, unity pantry, and refrigeration units for food and beverage disposal.New Horizon Foods Skilled Nursing Facility Food and Beverage Labeling Policy dated 1/1/25, indicated food items were labeled with what the item was, when it was

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement transmission-based precautions (TBP) and infection surveillance for 1 of 1 resident (R111) who had an active order to collect a stool sample for Clostridioides difficile (C. diff).Findings include: Review of R111's medical record included diagnosis list dated 7/24/25 which included End stage renal disease, diarrhea unspecified, and gastritis. Review of R111's Medication Administration Record (MAR) dated July 2025 indicated a physician order Collect Stool and send to the lab for C-Diff every loose stool D/C (discontinue) once the stool collected. The order was dated 7/21/25, and every shift through 7/24/25 had charted NO BM. R111’s Medication Administration Record for July 2025, directed staff to collect a stool sample and send to the lab for C. diff every shift for loose stool and to discontinue the order once R111’s progress notes did not indicate if R111 was placed on precautions or any additional details on when symptoms started and what prompted testing for C. diff. the stool was collected with start date of 7/21/25. R111’s progress notes dated 7/22/25 to 7/24/25, indicated R111 did not have a bowel movement to collect for a sample, or R111’s bowel movement was not collected due to R111 resting upon return from dialysis.The facility’s infection surveillance line list dated July 2025 did not include R111. Observation on 7/21/25 at 2:00 p.m., R111 room door was noted to have an Enhanced Barrier Precautions (EBP) sign. The sign indicated everyone must: clean their hands, including before and when leaving the room. Providers and staff must also: wear gloves and gown for the following high-contact resident care activities. Dressing, Bathing/Showering, Transferring, Changing Linen, providing hygiene, changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy tube, Wound care: any skin opening requiring a dressing. Interview on 7/21/25 at 2:15 p.m., R111's family indicated R111 had a loose stool in the morning, so the facility started the precautions again. R111's family indicated R111 was tested for C-diff (clostridium difficile) (inflammation of the colon caused by the bacteria Clostridium difficile) while in the hospital. Interview on 7/24/25 at 2:41 p.m., registered nurse (RN)-G indicated R111 had one loose stool on 7/21/25 when the nurse practitioner (NP) was here, and the NP wrote the order for the stool specimen, and the resident has not had another loose stool since. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/24/25 at 3:07 p.m., Licensed Practical nurse (LPN)-G verified R111's orders included an order for a stool sample, but R111 had not had a loose stool. LPN-G indicated if an order for a stool sample for C-diff was received, the resident should be put on contact precautions and Assistant Director of Nursing should be notified. LPN-G indicated the difference between EBP and Contact precautions are that every time someone enters the resident's room, they must wear PPE, no matter the reason. Interview on 7/24/25 at 3:14 p.m., RN-G indicated the Infection Control nurse should have been notified of the order and the resident should have been put on Contact Precautions until the stool specimen was collected and the results came back. RN-G indicated Contact Precautions means that all staff must wear PPE (Personal Protective Equipment) whenever entering the room. During interview on 7/24/25 at 1:56 p.m., the infection preventionist (IP) expected staff to place R111 on contact precautions until a negative lab returned for loose stools. IP stated R111 was not on the line list and did not know about R111’s loose stool(s) or order to test for C. diff. IP expected staff to notify them about R111’s symptoms and ordered test. During interview on 7/24/25 at 3:36 p.m., the director of nursing (DON) expected staff to place residents with a pending stool sample for C. diff on contact precautions to stop the potential spread of infection. The DON stated pending tests where not typically on the infection surveillance line list. The DON expected staff to document what happened and triggered the test, signs and symptoms, and what was tried. The [NAME] Health Care Center’s Infection Surveillance policy dated December 2020, indicated a written line list of infections to assist in organizing information about resident infections should be monitored and updated regularly to identify clusters, outbreaks, and other unusual infection patterns. The policy indicated cues for triggering a possible infection included antibiotic starts and resident signs and symptoms. The policy directed the IP to review infection surveillance definitions to determine if infection criteria were met if symptoms on the line list suggested a potential infection. Lifespark Senior Living and Senior Care Communities Infection Prevention and Control Program dated 4/2020, directed the IP to implement and monitor guidelines and procedures for isolation precautions. A specific policy on transmission based precautions was not provided.