STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlyn Heights Healthcare Center	2060 Upper 55th Street East Inver Grove Heights, MN 55077

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on observation and interview, the facility failed to provide a homelike environment to two out of two residents (R2, R3) reviewed for environment. R4 had been playing his music loudly and R2 and R3 had complaints of not being able to hear their music or their televisions. Findings Include: During an observation in the 600 hallway on 7/15/24 at 11:01 a.m., R4 had his door to his room open and loud explicit music playing. This explicit music could be heard from the front entrance of the facility as well as in the other hallways. During an observation in the 600 hallway on 7/15/24 at 12:28 p.m., R4 had his door to his room open and loud music playing. This music could be heard from the front entrance of the facility as well as in the other hallways. R2's medical records printed on 7/16/24 indicated R2 was admitted to the facility on [DATE] with a primary diagnosis of cerebral palsy. R2's additional diagnoses included polyneuropathy, major depressive disorder, and mild intellectual disabilities. R2's brief interview for mental status (BIMS) assessment dated [DATE] indicated R2 had a score of 15, which indicated R2 was cognitively intact. R3's medical records printed on 7/16/24 indicated R3 was admitted to the facility on [DATE] with a primary diagnosis of systemic lupus erythematosus. R3's additional diagnoses included polyneuropathy, generalized anxiety disorder, major depressive disorder, and insomnia. R3's BIMS assessment dated [DATE] indicated R3 had a score of 15, which indicated R3 was cognitively intact. R4's medical records printed on 7/16/24 indicated R4 was admitted to the facility on [DATE] with a primary diagnosis of orthopedic aftercare following a joint replacement or spinal surgery. R4's additional diagnoses included major depressive disorder, anxiety disorder, personality disorder, and dysthymic disorder. R4's diagnoses did not indicate R4 had hearing impairment. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's minimum data set (MDS) dated [DATE] indicated R4 had a BIMS score of 14, which indicated R4 was cognitively intact. The MDS indicated R4 had adequate hearing and no hearing aides. During an interview with R2 on 7/15/24 at 12:31 p.m., R2 stated R4 had been playing his music very loud for a few days and it had been bothering her. R2 stated she told her nurse about her concerns but was unsure if staff investigated her concerns. During an interview with R3 on 7/15/24 at 12:41 p.m., R3 stated R4 started playing his music very loudly last week. R3 stated the music was bothering her as she could not hear her television very well when he was playing his music loud. During an interview with R4 on 7/15/24 at 12:55 p.m., R4 stated he had just started playing his music very loud with the door open maybe in the last two weeks. R4 stated he had been playing his music loud because other residents were playing their music and television loud. R4 stated he was playing his music loud to anger the other residents who were playing their music and television loud. R4 stated he usually listened to his music on his headphones, but since he paid to live there, he could play his music when he wanted and how loud he wanted. During an interview with the director of nursing (DON) on 7/15/24 at 3:44 p.m., the DON stated the facility creates a homelike environment by honoring the resident's wishes, cleanliness, providing a well-lite facility, ensuring the facility was free of accidents and hazards, and by creating an odor-free environment. The DON stated residents could have their music on in their rooms at a level that did not disturb other residents. The DON stated if she had heard concerns about music or noises being too loud, that she would approach the resident and ask them to turn their music or television down. The DON stated she had not heard of any complaints from residents about loud music or television. During my interview with the administrator on 7/17/24 at 4:09 p.m., the administrator stated if a resident had a concern about music or television distractions, himself, the DON, and the social worker would have a conversation with the other resident to see if they could find an alternative solution to ensure everyone's needs were being met. A policy for a homelike environment was requested and none was received.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on interview and record review the facility failed to develop a comprehensive care plan to meet the residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment for one of one resident (R1) reviewed for care plans. R1 was on dialysis, used tube feeding to get his nutrients, and had respiratory concerns, and activities of daily living and those care areas were not addressed on his care plan. Findings include: R1's medical records printed on 7/15/24 indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of sepsis. R1's additional diagnoses included nondisplaced fracture of olecranon process without intraarticular extension of right ulna, hypokalemia, falls, a kidney transplant recipient, presence of a cardiac pacemaker, anemia, gastro-esophageal reflux disease, other mechanical complication of surgically create arteriovenous fistula, moderate protein-calorie malnutrition, bronchiectasis, dysphagia, end-stage renal disease, congestive heart failure, chronic obstructive pulmonary disease, age-related cataract of the right eye, peripheral vascular disease, lymphedema, osteoporosis, schizoaffective disorder, narcissistic personality disorder, and recurrent and persistent hematuria. R1's hospital records dated 5/28/24 indicated prior to R1 being admitted to the facility, he was at a hospital from 3/22/24 to 5/28/24 and diagnosed with sepsis, pneumonia, and respiratory failure. Hospital records indicated R1 was dependence upon hemo-dialysis, had a CPAP machine, he was on a tube feeding program, and was on a therapeutic renal diet. Hospital records indicated R1 had a history of recurrent urinary tract infections (UTI). These hospital records were in his electronic medical record (EMR) at the facility and were obtained upon admission to the facility. R1's minimum data set (MDS) dated [DATE] indicated R1 admitted to the facility on [DATE] from a short term hospital stay. The MDS identified R1 wore corrective lenses, had a brief interview for mental status (BIMS) score of 15, which indicated R1 was cognitively intact, R1 had preferences for customary routine activities, functional limitations included impairment with lower extremity, R1 had listed functional abilities and goals, had an indwelling catheter and was frequently incontinent of bowel, R1 had diagnosis of medical complex conditions, occasional pain, had a feeding tube, was at risk for developing pressure ulcers, was taking routine antipsychotic medication, and had respiratory and dialysis needs. R1's care plan created on 5/29/24 and revised on 7/3/24 lacked the following information: -R1 was on anti-psychotic medications. The intervention was to attempt non-pharmacological interventions and to observe for effectiveness. The care plan did not indicate what non-pharmacological interventions should be used. -Did not indicate R1's cognitive status including R1's BIMS score and how R1 communicates. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Did not indicate R1's preferences for customary routines and activities or whether R1 likes to pursue activities as a group or individually. -The care plan did not indicate R1's bathing preferences and frequency, or oral cares including whether R1 had his own teeth or dentures. -R1's care plan did not indicate R1 was at risk for urinary tract infections due to his supra pubic catheter and urinary and bowel incontinence. -R1's care plan did not indicate how R1 ambulates, including a wheelchair, walker, side rails, or grab bars. -R1's care plan did not indicate R1's sleep hygiene including usual sleep patterns, preferred bedtime, preferred awake time, factors contributing to poor sleep habits, or non-pharmacological interventions to promote sleep. -R1's care plan did not include R1's use of oxygen, respiratory therapy, or dialysis including frequency, location, contact information, site monitoring and care, identifying and preventing infections and complications, and what to do in event of emergency or weather-related delays in care. During an interview with the director of nursing (DON) on 7/15/24 at 3:44 p.m., the DON stated the baseline care plan is completed within forty-eight hours of the resident being admitted , then staff will complete assessments, and then the comprehensive care plan would be completed. During an interview with nursing assistant (NA)-C on 7/16/24 at 3:06 p.m., NA-C stated she would look in a resident's care plan to see how the resident is cared for. During an interview with the DON on 7/16/24 at 3:37 p.m., the DON stated a resident's COPD should be on a resident's care plan. The DON stated the nursing staff and nursing management was responsible for creating a resident's comprehensive care plan. The DON stated a resident's dialysis treatment should be a part of a resident's care plan. The DON stated the interventions for a dialysis treatment should have included monitoring, the order, the date, and time the resident should be going to dialysis, restrictions, limitations, and transportation information. During an interview with the dietitian on 7/16/24 at 4:06 p.m., the dietitian stated she would create the care plan by looking at the resident's medical record and read progress notes. The dietitian stated she would expect nursing assistants to look in a resident's chart to see how the resident is cared for. During an interview with the DON on 7/17/24 at 2:26 p.m., the DON stated it is a collaborative effect with the minimum data set (MDS) coordinators and nursing management to create a resident's comprehensive care plan. The DON stated nurses are the only ones who had access to the medication administration record (MAR) and the treatment administration record (TAR), and the nurses would be the only staff members who can operate in the MAR and TAR. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview the MDS coordinator (MDSC)-A on 7/17/24 at 2:49 p.m., MDSC-A stated the nurses, and the nurse managements create the care plan, and he would review the care plans. MDSC-A stated he can add information to the care plan and remove things he saw fit in a care plan. MDSC-A stated when he came to a resident on tube feeding, the nurse managers create that care plan area. MDSC-A stated there was a section of the MDS to check to ensure the care plan is complete. MDSC-A stated he would not go into detail when reviewing the care plan; he would just ensure the care plan is signed by the appropriate staff members. MDSC-A stated he would have a concern if a resident were on tube feedings and that information was not on a resident's care plan. MDSC-A stated if tube feeding information was not on the resident's care plan, he would ask the nurse managers to put that information into the resident's care plan. MDSC-A stated the same thing would be true if a resident was on dialysis. MDSC-A stated he would expect a resident's pertinent diagnoses to be put in a resident's care plan, including tube feeding, dialysis, and any complications that would go with those diagnoses. During an interview with MDSC-B on 7/17/24 at 3:13 p.m., MDSC-B stated if there was a significant change with a resident, she would expect the nurse managers to assist in assessing the resident. MDSC-B stated she would expect dialysis to be on a resident's care plan and what type of dialysis access the resident had. MDSC-B stated she would expect a resident's tube feeding information to be on a resident's care plan. MDSC-B stated she would expect the dietitian to put in a resident's tube feeding information into the resident's care plan. MDSC-B stated after assessments were completed, she would typically sign off on the nursing parts of the care plan, but stated the whole care plan was nursing related. During an interview with the administrator on 7/17/24 at 4:09 p.m., the administrator stated his expectations would be for the care plan to be created by the interdisciplinary team. The administrator stated when a resident was admitted to the facility, or if there was a significant change in the resident, the facility needed to ensure the resident had everything they needed to thrive, and that protocols and assessments were in place. The administrator stated he would expect dialysis and tube feeding information to be on a resident's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Person Centered Care Plan created on 1/2023 and revised on 10/2017 indicated the baseline care plan should include, but not limited to, physician orders, therapy orders, a summary of the resident's medications and dietary instructions, any services, and treatments to be administered by the facility and personnel acting on behalf of the facility, and any updated information based on the details of the comprehensive care plan. The policy stated the comprehensive person-centered care plan should contain measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments. The policy stated the overall person-centered care plan should be orientated towards preventing avoidable declines, management of risk factors, preserving and building on a resident's strength's, respecting a resident's personal preferences, include specific care goals, treatment preferences, and desired outcomes of care, and to include a resident's strengths and care needs. The policy stated an area to address on the comprehensive care plan is a resident's cognitive status including current BIMS score, how a resident makes self-understood, and how the resident understands. The policy stated an area to address on the comprehensive care plan is a resident's behavior including non-pharmacological interventions, and psychoactive medication class along with the appropriate diagnosis or indication for use. The policy stated an area to address on the comprehensive care plan is mood which includes PHQ-9 score, target behaviors, and non-pharmacological interventions. The policy stated an area to address on the comprehensive care plan is activity pursuit including preferences for customary route and activities, and whether the resident likes to pursue activities as a group or independently. The policy stated an area to address on the comprehensive care plan is hygiene including bathing preferences and frequency, and oral care including if the resident had their own teeth or dentures. The policy stated an area to address on the comprehensive care plan is elimination including risk for urinary tract infections. The policy stated an area to address on the comprehensive care plan is all current acute and chronic clinical conditions for which the resident was receiving medications, treatments, and/or care, which may include but not limited to COPD, heart disease, and infections. The policy stated an area to address on the comprehensive care plan is mobility and fall risk including a resident's mobility, and devices used such as a walker, wheelchair, grab bars, and side rails. The policy stated an area to address on the comprehensive care plan is sleep hygiene which includes usual sleep pattern, preferred bedtime, preferred wake time, factors contributing to poor sleep habits, non-pharmacological interventions to promote sleep, and sleep monitoring. The policy stated an area to address on the comprehensive care plan is special treatments and procedures including oxygen. The policy stated an area to address on the comprehensive care plan is respiratory therapy including short of breath when resting, with activity, or when lying flat. The policy stated an area to address on the comprehensive care plan is dialysis including frequency, location, contact information, site monitoring/care, identifying/preventing infections, and complications, and what to do in an event of emergency or weather-related delays in care. The facility policy titled Dialysis Care Plan and Treatment Sheet policy and procedure effective 2/2019 stated the dialysis care plan should include the name of the dialysis location with the phone number, the days the resident is scheduled to receive dialysis, monitoring for complications following dialysis including hypotension, febrile reaction, bleeding, and infection, emergency measures, fluid restrictions including measured intake and for nursing to monitor for compliance or non-compliance, precautions to include, monitoring the vascular access including to check bruit and thrill, checking for redness, edema, and drainage position, monitoring weight and vital signs, send a meal/snack to dialysis, shunt dressings to be changed, what to do if a resident refuses to go to dialysis, and to monitor emotional status and provide psychosocial interventions as indicated.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on interview and record review the facility failed to monitor and assess the hydration status for one of one resident (R1) reviewed for hydration. R1 had an order for tube feedings with direction to adjust the free water flushes pending hydration status one time a day and facility staff were not monitoring or assessing R1's hydration status. Findings include: R1's medical record printed on 7/15/24 indicated R1 was admitted to the facility on [DATE] due to sepsis. R1's additional diagnoses included hypokalemia, moderate protein-calorie malnutrition, bronchiectasis, dysphagic, chronic obstructive pulmonary disease (COPD), gout, and lymphedema. R1's hospital discharge papers dated 5/22/24 indicated R1 had a gastrostomy-jejunostomy placed on 5/18/24. The record indicated R1 was on tube feedings with an oral diet. The record indicated R1 was on a Novasource Renal diet administered at one hundred twenty milliliters (mL) per hour for nine hours. The record indicated R1 was to receive thirty mL before and after each feeding. The record indicated R1's estimated calorie needs were one thousand twenty to two thousand ninety per day. R1's admission record indicated R1 was not on fluid restrictions but was on moderately thick liquids. R1's treatment administration record (TAR) dated 7/2/24 indicated R1 was to receive tube feeding for Novasource Renal at one hundred twenty mL per hour for nine hours a day via percutaneous endoscopic gastrostomy (PEG)- J tube with thirty milliliters (mL) free water flushes every six hours via both G and J ports. The TAR indicated to adjust the free water flushes pending hydration status one time a day. The TAR indicated this was discontinued on 7/9/24. R1's progress note dated 7/2/24 written by the dietitian indicated R1 received Novasource one hundred twenty mL per hour for nine hours overnight and if not tolerated to reduce to ninety mL per hour over twelve hours over night but that nursing had reported tolerating at one hundred twenty mL per hour at that time. The progress note indicated water flushes with thirty mL of water four times a day. The progress note indicated to adjust free water flushes pending hydration status. The progress note indicated R1 was to receive nutrisource fiber oral packet directed at one packet via G-tube three times a day for constipation with flush tube with fifteen mL water before, mixing the nutrisource fiber oral packet with sixty to one hundred twenty mL water until dissolved, then flushing the tube with thirty to sixty mL of water after. R1's hospital records from 7/8/24 indicated when R1 was seen by the provider in the emergency department, R1's mucous membranes were dry and was unable to tolerate secretions. The hospital records indicated R1 would require aggressive fluid resuscitation. During an interview with R1's guardian on 7/15/24 at 1:55 p.m., the guardian stated she visited R1 at the dialysis center on 7/8/24 and the dialysis nurse (DN) had called an ambulance because R1 was so dehydrated they could not dialyze him. The guardian stated R1 was partially responsive. The guardian stated DN called for an ambulance and R1 was sent to the hospital. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with nursing assistant (NA)-C on 7/16/24 at 3:06 p.m., NA-C stated she had fed R1 around 8:00 a.m. on 7/8/24. NA-C stated R1 ate about 5% of his food and had about two hundred forty mL. NA-C stated about ten minutes after she fed R1, R1 had vomited. During an interview with the director of nursing (DON) on 7/16/24 at 3:37 p.m., the DON stated she hadn't personally assessed or seen R1 dehydrated. The DON stated the dietitian, and the facility provider will determine the need for an increase or decrease in the amount of free water flushes were given to R1. The DON stated the nursing staff would be monitoring R1's fluid intake. The DON stated the fluid intake documentation in R1's tasks only included fluids R1 drank orally, and staff would document the free water flushes on the TAR and MAR. During an interview with the dietitian on 7/16/24 at 4:06 p.m., the dietitian stated she would be responsible for tracking R1's nutritional needs, including his fluid intake. The dietitian stated she was responsible for determining R1's hydration status. The dietitian stated she had thought R1 was meeting his nutritional needs. The dietitian stated she would adjust the free fluid flushes if she heard from the nursing staff stating he may have needed an adjustment. The dietitian stated R1 had not presented to her with dehydration. The dietitian stated she would chart on feeding tube nutritional values monthly. During an interview with the DON on 7/17/24 at 2:26 p.m., the DON stated the interdisciplinary team met with the dietitian and discussed that R1 was not taking any fluids or foods orally and the dietitian looked at R1's current situation and deemed R1 was getting sufficient calories. During an interview with the administration on 7/17/24 at 4:09 p.m., the administrator stated he would expect when it came to hydration status, that the staff would do a care conference with R1 and his family and note any significant changes. The administrator stated he would expect that hydration status would be monitored daily. A policy on assessing hydration status and needs were requested and none was provided.

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on interview and record review, the facility failed to provide the ordered respiratory care and obtain an order to administer oxygen for one of one resident (R1) reviewed for respiratory status. R1 was harmed when he was admitted to the facility with an order to provide respiratory chest physiotherapy three times a day, was not provided the ordered therapy, contributing to R1's death. In addition, R1 received oxygen therapy without a physician order. Findings include: R1's medical record indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of sepsis. R1's additional diagnoses included bronchiectasis, dysphagia, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD). R1 was discharged from the facility on [DATE]. R1's hospital discharge summary dated [DATE] indicated R1 was inpatient from [DATE] to [DATE]. R1's admitting diagnosis was respiratory failure with hypoxia, including acute kidney injury, delirium, pneumonia, two-time renal transplant, hypertensive heart and chronic kidney disease with heart failure and unspecified stage chronic kidney disease, hypothyroidism, anemia, pacemaker cardiac status, immunodeficiency due to drugs, congestive heart failure, urinary retention, schizoaffective disorder (chronic), and infection and inflammatory reaction due to cystostomy catheter. R1 was diagnosed with severe sepsis from Escherichia coli (E. coli) and Enterobacter cystitis in the setting of suprapubic catheter with possible component of community-acquired pneumonia. R1's hospital course was complicated by recurrent episodes of transient hypoxia thought to be due to either mucus plugging or recurrent aspiration events. R1 continued to have these episodes despite transition to jejunal feeds and while taking nothing by mouth (NPO). R1 was on a modified diet for dysphagia and had scheduled dialysis. R1's heath was improving, and he was free of communicable disease. It was determined R1 required skilled nursing care. Respiratory therapy recommendations included DuoNebs followed by Hypertonic saline nebulizers three times a day done simultaneously with chest vest therapy (Also called chest physiotherapy. Chest physiotherapy is a treatment used to improve breathing by the indirect removal of mucus from the breathing passages.) The facility was to ensure nebulizer was cleaned daily. R1's treatment administration record (TAR) dated [DATE] indicated nursing was to complete a pre-and-post dialysis assessment before dialysis and on return from dialysis on Mondays, Wednesdays, and Fridays. The pre-dialysis assessment included vital signs, level of consciousness, if the resident had experienced any muscle cramping, itching, discomfort, or pain, and if there was a thrill and bruit noted. The post-dialysis assessment included vital signs, if the resident had experienced any dizziness, nausea, vomiting, fatigue, chills, shaking, muscle weakness, skin flushing, itching, or diarrhea, if there was a thrill and bruit noted, and a place to enter access site notes. On [DATE], the TAR signed by registered nurse (RN)-A indicated the pre-and-post dialysis assessment was completed but an assessment was not completed. The pre-and-post dialysis assessment had only been completed on [DATE], [DATE], and [DATE] during his admission. R1's progress note written by the social worker (SW) on [DATE] at 1:39 p.m. indicated the SW was working on getting an order for the vest. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	R1's medical record indicated no documentation regarding R1's chest physiotherapy vest, the order for the chest physiotherapy vest, or treatments between [DATE] and [DATE]. R1's minimum data set (MDS) dated [DATE] indicated R1 had asthma, COPD, or chronic lung disease such as chronic bronchitis. The MDS indicated R1 received zero days of respiratory therapy for fifteen minutes in the last seven days. R1's provider visit notes dated [DATE] indicated R1 had not been getting his percussion vest treatments and the provider had educated nursing staff on the vest treatments. The provider indicated R1 was to have his percussion vest used routinely. R1's progress note written by the SW on [DATE] at 2:21 p.m., the SW stated R1 has orders for a vest. R1's physician order dated [DATE] indicated staff to administer oxygen two liters as needed via nasal canula. R1's TAR dated [DATE] indicated R1 was to use oxygen as needed at two liters per minute via nasal cannula as needed for shortness of breath and to record rate as needed. This treatment was not signed off by nursing staff from [DATE] to the time R1 was discharged . The TAR indicated staff was to obtain R1's oxygen level and to record the results every shift. R1's TAR indicated nursing staff was to ensure that R1's portable oxygen tank was filled prior to use of N.O. R1's TAR indicated nursing was to check oxygen tubing and set up for usage weekly on the night shift and replace it is had been used. R1's physician orders dated [DATE] indicated R1 was to receive vest treatment therapy every night with nebulizer treatment for bronchiectasis. There was no summary of the provider visit with R1 or the provider assessing R1's lung sounds. R1's TAR dated [DATE] indicated R1's Pul vest was to be used every night with his nebulizer treatment for fifteen minutes one time a day. The dates this treatment was completed was [DATE], [DATE], and [DATE]. This order was discontinued on [DATE] when R1 was hospitalized for an unrelated fall. R1's hospital discharge record indicated R1 was admitted to the hospital from [DATE] to [DATE] after a witnessed fall. R1's admitting diagnosis was a fall including closed fracture of proximal end of right ulna, laceration of left lower extremity, hypomagnesemia, hypophosphatemia, acute hypokalemia, cardiac pacemaker, dysphagia, end stage renal disease, closed fracture of right olecranon process, hypotension, malnutrition, hypovolemia, and anemia. Assessments indicated R1 had crackle/coarse and expiratory wheezes in all lobes of R1's lungs. During R1's hospitalization , respiratory therapy administered R1's nebulizer and performed chest physiotherapy. R1 was to continue with his vest therapy and saline nebulizers and DuoNebs as ordered. R1's medication administration record (MAR) dated [DATE] indicated R1 was to receive ipratropium-albuterol inhalation solution with the directions to inhale 3 milliliters (mL) orally via nebulizer three times a day for shortness of breath. The order indicated for staff to listen to R1's lungs and to record if R1's lungs were clear, crackles, wheezes, rales, or rhonchi. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlyn Heights Healthcare Center	2060 Upper 55th Street East Inver Grove Heights, MN 55077

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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 0695 Level of Harm - Actual harm Residents Affected - Few	R1's brief interview for mental status (BIMS) dated [DATE] indicated R1 had a score of 14, which indicated R1 was cognitively intact. R1's Admission/Readmission and Care Plan Nursing assessment dated [DATE] indicated R1 was not on a nebulizer, R1 did not have oxygen needs, and R1 had normal lung sounds. R1's progress note written by the nurse manager (NM) on [DATE] at 4:58 p.m. indicated R1 did not have any respiratory devices. R1's vital signs documented on [DATE] at 2:19 a.m., indicated R1's respirations were twenty breaths per minute, ninety-four percent oxygen on room air, blood pressure was one hundred ten over seventy millimeters of mercury (mmHg) while lying and the blood pressure was taken on his right arm, pain level was zero, pulse was eighty-four beats per minute, and temperature was ninety-six point nine degrees Fahrenheit taken by tympanic. R1's vital signs documented on [DATE] at 2:01 p.m. indicated R1's oxygen was ninety-six percent while R1 was on oxygen via nasal cannula, blood pressure was one hundred twenty over seventy-four mmHg while lying and blood pressure was taken on right arm, pain score was five, pulse was seventy beats per minute, and lungs were clear. R1's temperature and respirations were not taken at this time. Medical records indicated lung sounds were clear on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. R1's progress note dated [DATE] at 5:56 p.m., the NM stated he received a voicemail from the dialysis clinic that R1 had shortness of breath, so the dialysis center sent R1 to the emergency room . No additional progress notes were made on [DATE]. R1's hospital discharge record dated [DATE] indicated R1 was transferred from the dialysis clinic to the hospital due to hypotension and shortness of breath. Hospital records indicated R1 was admitted to the hospital due to acute respiratory failure with hypoxia, COPD exacerbation, and pneumonia of left lower lobe due to infectious organism. The records indicated R1 was diagnosed with methicillin-resistant staphylococcus aureus (MRSA). Hospital records indicated family member (FM)-A indicated she saw R1 at the facility on [DATE] and at that time R1 had been visibly distressed, was concerned R1 was not getting his physiology vest treatments, appeared to be disoriented, was exhausted, and poorly cared for. The hospital records indicated R1 had bilateral significant wheezing, crackles, and had coarse sounds in his lungs. Hospital records indicated R1 had respiratory symptoms brewing for a few days. The hospital records indicated R1 had a history of mucous plugging and was unclear whether he was getting his chest physiotherapy at the facility. Hospital records indicated R1 had severe sepsis from community acquired pneumonia, COPD, and aspiration pneumonitis. Hospital records indicated R1 was transferred to the intensive care unit (ICU). Hospital records indicated R1 continued to have increased oxygen requirements, was altered, unresponsive to questions, and unable to tolerate secretions. Hospital records indicated R1 died on [DATE] due to severe sepsis with shock, pneumonia of left lower lobe due to infectious organism, and acute hypoxic respiratory failure. During an interview with nursing assistant (NA)-B on [DATE] at 12:32 p.m., NA-B stated R1 did not have respiratory problems during his admission at the facility. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	During an interview with registered nurse (RN)-A on [DATE] at 12:49 p.m., RN-A stated he was R1's nurse on [DATE] and R1 had gone to dialysis that morning. Then on [DATE] at 2:48 p.m., RN-A stated he believed he had taken R1's vital signs on [DATE] but could not remember what the vital sign readings were. RN-A stated from what he remembered, R1 had been a little more tired than his baseline, but that his appearance was nothing out of the ordinary. RN-A stated he does not remember R1's lungs being wheezy on [DATE]. On [DATE] at 3:00 p.m., RN-A stated he did not see any concerns with R1 leaving for dialysis on [DATE]. During an interview with the NM on [DATE] at 12:59 p.m., the NM stated R1's dialysis center called him and left a voicemail from the DN stating R1 was having shortness of breath and the dialysis center sent R1 to the hospital and directed him to follow up with the hospital. The NM stated R1 never complained of shortness of breath to him. The NM stated R1 was on continuous oxygen, and he was compliant with his oxygen use. The NM stated he would perform oxygen audits on the residents to see how much oxygen residents are on versus the resident's respirations but noted he did not perform any oxygen audits on R1. During an interview with R1's guardian on [DATE] at 1:09 p.m., the guardian stated R1 had issues with his lungs where he would not cough up his mucous. The guardian stated R1 had an order for a vest treatment weeks prior to his admission to the facility. The guardian stated the vest treatment would help R1 get rid of the mucous in his lungs. During an interview with FM-A on [DATE] at 1:55 p.m., FM-A stated R1 had not been consistently receiving his vest therapy. FM-A stated she would ask R1 if he was getting his vest therapy and R1 stated he was not getting his vest therapy. FM-A stated R1 was cognitively intact. FM-A stated she visited R1 on [DATE] and she had asked R1 if he received his vest therapy, and he stated no. FM-A stated she had called the director of nursing (DON) and left her a voicemail stating R1 was supposed to be getting his vest therapy with his nebulizer treatments, but FM-A stated she had not received a call back. FM-A stated the respiratory specialist at the hospital prior to R1's admission to the facility stated R1's vest treatment was key to R1 staying alive. During an interview with the DON on [DATE] at 3:44 p.m., the DON stated once a resident is accepted and comes to the facility, the nurse managers who review the admission paperwork and till put the orders into the resident's MAR and TAR. The DON stated her expectation was when residents were admitted to the facility with treatment orders, the orders would be transcribed, and the nurses would follow those treatment orders. The DON stated the facility was notified by FM-A that R1 was supposed to be receiving vest treatment orders but that the facility did not have an order for the vest treatments. The DON could not state when FM-A told her R1 was supposed to be receiving his vest treatments. The DON stated the facility received an order for the vest treatments by the in-house physician and put the vest order in R1's TAR on [DATE]. The DON stated the order was discontinued on [DATE] because R1 went to the hospital. The DON stated if a resident was going to be in the hospital for over twenty-four hours, then the facility will discontinue all orders and then revisit the resident's orders when they come back from the hospital. The DON stated if she could remember, the facility did not have an order for the vest treatments when he was admitted to the facility and the facility did not have a vest treatment order prior to [DATE]. The DON stated the vest treatment order was missed by the nurse managers because the actual order was not in R1's after visit summary from his hospitalization from [DATE] to [DATE] or his hospitalization from [DATE] to [DATE]. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	During an interview with the DON on [DATE] at 4:22 p.m., the DON stated she had been trying to find a respiratory care and services policy and procedure, but she could not find one. The DON stated the facility uses the standards of care. The DON stated the facility did not have a standards of care policy or procedure. During an interview with the dialysis nurse (DN) on [DATE] at 9:13 a.m. indicated R1 came to the dialysis center on [DATE] with labored breathing. DN stated family member (FM)-A came to the dialysis center on [DATE] and stated R1 was supposed to get a vest treatment for mucous plugs and R1 had been declining the weekend prior to [DATE]. DN stated FM-A stated R1 stated he was not receiving his vest treatment. DN stated she sent R1 to the emergency department via ambulance due to his labored breathing. It is unknown whether the dialysis clinic started R1's dialysis. During an interview with the nurse practitioner (NP) on [DATE] at 9:23 a.m., the NP stated R1's hospital discharge paperwork from [DATE] indicated R1 had an order for vest therapy and her order for the vest therapy on [DATE] was just a continuation of that. The NP stated when she saw R1 he stated he was supposed to be receiving his vest therapy and he was not sure the facility had an order to provide that service. The NP stated she had just written the order for the vest treatment anyways. The NP stated the vest treatment was brought up in a conversation between R1 and herself and she had written the vest therapy order to be safe. The NP stated she did not have access to R1's admission paperwork for a month prior to writing the vest therapy order. The NP stated if R1 had not received his vest therapy, R1's lungs would become more congested, and mucus would build up. The NP stated she would have had to consult with the pulmonary specialist about further complications R1 could have received for not receiving his vest therapy. An interview was attempted with the dialysis center on [DATE] at 2:31 p.m., 3:17 p.m., [DATE] at 9:20 a.m., 10:07 a.m., and 3:35 p.m., but the phone kept ringing and was unable to leave a voicemail. During an interview with NA-C on [DATE] at 3:06 p.m., NA-C stated she did not remember R1 wheezing on [DATE]. NA-C stated he looked very tired on [DATE]. NA-C stated she did not remember what R1's appearance looked on [DATE] because she was not focused on R1's appearance. NA-C stated she and RN-A were the only ones who had interactions with R1 on the morning of [DATE]. During an interview with the DON on [DATE] at 3:37 p.m., the DON stated the nurse managers would be completing the resident's orders upon admission. The DON stated if a resident would be in the hospital for over twenty-four hours, the facility would discontinue all physician orders, but would keep the house standing orders if the resident had any. The DON stated the facility assessed R1's lung and respiratory status on [DATE] and his lungs were clear. During an interview with the medical doctor (MD) who saw R1 while he was hospitalized from [DATE] to [DATE] on [DATE] at 9:25 a.m., the MD stated R1's missed vest treatments played a huge part in his passing. The MD stated he had severe sepsis probably from the pneumonia from the mucus in his lungs. The MD stated the vest treatments would have helped cleared the mucus in his lungs. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	During an interview with licensed practical nurse (LPN)-A on [DATE] at 2:15 p.m., LPN-A stated she worked with R1 on [DATE] but could not tell what R1's condition was that day. LPN-A stated she did not know R1's baseline due to her being newly employed by the facility. LPN-A stated she did not think she had any concerns with R1 on [DATE]. LPN-A stated if she did have concerns with R1 on [DATE] she would have called and reported it to the physician and she does not recall having to contact the physician. During an interview with DON on [DATE] at 2:26 p.m., the DON stated it would have been the nurse working with R1 on [DATE] that deemed him appropriate to send R1 to dialysis that day. During an interview with RN-F on [DATE] at 3:02 p.m., RN-F stated R1 did not get out of bed on [DATE] and RN-F was concerned about it. RN-F stated R1 got out of bed on [DATE] because FM-A was visiting, and RN-F had no concerns. During an interview with the administrator on [DATE] at 4:09 p.m., the administrator stated his expectations when it comes to a resident being admitted to the facility would be the nurses and the nurse managers will enter the orders and communicate with the pharmacy to ensure the facility had everything for that order. The administrator stated if the nurses or nurse managers had any questions or concerns with the order, his expectation would be the nurses and nurse managers would seek clarification from the provider who wrote the order. The administrator stated he would expect nurses and nurse managers to go through a resident's admission paperwork to look for treatments and medication orders prior to the resident being admitted to the facility. A respiratory services and care policy and procedure was requested, and none was received.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on interview and record review the facility failed assess a resident before and after dialysis for one of one resident (R1) reviewed for dialysis. Findings include: R1's medical record printed on 7/15/24 indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of sepsis. R1's additional diagnoses included a kidney transplant recipient, anemia in chronic kidney disease, end stage renal disease, and dependence on renal dialysis. R1's treatment administration record (TAR) dated 5/29/24 indicated nursing was to complete a pre-and-post dialysis assessment before dialysis and on return from dialysis on Mondays, Wednesdays, and Fridays. The pre-dialysis assessment included vital signs, level of consciousness, if the resident had experienced any muscle cramping, itching, discomfort, or pain, and if there was a thrill and bruit noted. The post-dialysis assessment included vital signs, if the resident had experienced any dizziness, nausea, vomiting, fatigue, chills, shaking, muscle weakness, skin flushing, itching, or diarrhea, if there was a thrill and bruit noted, and a place to enter access site notes. R1's minimum data set (MDS) dated [DATE] indicated R1 was on dialysis. R1's medication administration record (MAR) dated 6/29/24 indicated R1 had dialysis on Monday, Wednesday, and Friday's at 11:00 a.m. R1's record review indicated three dialysis pre-and-post assessments were completed from the time of admission. The three assessments were completed on 6/10/24, 6/17/24, and 6/19/24. During an interview with registered nurse (RN)-A on 7/16/24 at 2:48 p.m., RN-A stated the pre-and-post dialysis assessments should have been done prior to R1 leaving for dialysis and when he would come back from dialysis. RN-A stated the pre-and-post dialysis assessment was just a Yes or No question in R1's TAR. During an interview with the director of nursing (DON) on 7/16/24 at 3:37 p.m., the DON stated the nurses should have been monitoring R1 before and after his dialysis. The DON stated the nurses should have been completing the pre-and-post dialysis assessment each time a resident goes to dialysis and when the resident comes back to the facility from dialysis. The DON stated the pre-and-post dialysis assessment consists of vital signs, level of consciousness, pain, and if the resident had a fistula, the nurses should be assessing for that. During an email correspondence between writer and administrator on 7/16/24 at 4:37 p.m., the administrator stated there was not a contract between the facility and the dialysis center. During an interview with the DON on 7/17/24 at 2:26 p.m., the DON stated R1 had a TAR order to prompt the nurses to go into the resident's assessments and complete a pre-and-post dialysis assessment. The DON stated she had noticed R1 only had 3 pre-and-post dialysis assessments since he was admitted to the facility, and that was concerning to her. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A dialysis assessment policy and procedure was requested, and none was received. A dialysis assessment policy and procedure was requested, and none was received.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on interview and record review, the facility failed to ensure a medical record was accurately document vital signs and assessments for one of one resident (R1) reviewed for medical records. R1's treatment administration record (TAR) indicated R1 was to have a pre-and-post dialysis assessment done three days a week and all but three of those assessments were not completed. R1's vital signs were documented while he was not in the facility. Findings include: R1's medical record indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of sepsis. R1's additional diagnoses included bronchiectasis, dysphagia, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD). R1 was discharged from the facility on [DATE]. R1's hospital discharge summary dated [DATE] indicated R1 was inpatient from [DATE] to [DATE]. R1's admitting diagnosis was respiratory failure with hypoxia, including acute kidney injury, delirium, pneumonia, two-time renal transplant, hypertensive heart and chronic kidney disease with heart failure and unspecified stage chronic kidney disease, hypothyroidism, anemia, pacemaker cardiac status, immunodeficiency due to drugs, congestive heart failure, urinary retention, schizoaffective disorder (chronic), and infection and inflammatory reaction due to cystostomy catheter. R1 was diagnosed with severe sepsis from Escherichia coli (E. coli) and Enterobacter cystitis in the setting of suprapubic catheter with possible component of community-acquired pneumonia. R1's hospital course was complicated by recurrent episodes of transient hypoxia thought to be due to either mucus plugging or recurrent aspiration events. R1 continued to have these episodes despite transition to jejunal feeds and while taking nothing by mouth (NPO). R1 was on a modified diet for dysphagia and had scheduled dialysis. R1's heath was improving, and he was free of communicable disease. It was determined R1 required skilled nursing care. Respiratory therapy recommendations included DuoNebs followed by Hypertonic saline nebulizers three times a day done simultaneously with chest vest therapy (Also called chest physiotherapy. Chest physiotherapy is a treatment used to improve breathing by the indirect removal of mucus from the breathing passages.) The facility was to ensure nebulizer was cleaned daily. R1's medication administration record (MAR) dated [DATE] indicated R1 was to received Ipratropium-Albuterol Inhalation Solution at three milliliters (mL) inhaled orally via nebulizer three times a day for shortness of breath. The entry indicated staff was to listen and record R1's lung sounds three times a day before and after the Ipratropium-Albuterol Inhalation Solution treatment. Staff marked that the lungs were clear everyday and every time the Ipratropium-Albuterol Inhalation Solution was given except for when R1 was hospitalized from [DATE] to [DATE] and from [DATE] to [DATE]. The order was discontinued on [DATE] due to R1 being discharged . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's treatment administration record (TAR) dated [DATE] indicated nursing was to complete a pre-and-post dialysis assessment before dialysis and on return from dialysis on Mondays, Wednesdays, and Fridays. The pre-dialysis assessment included vital signs, level of consciousness, if the resident had experienced any muscle cramping, itching, discomfort, or pain, and if there was a thrill and bruit noted. The post-dialysis assessment included vital signs, if the resident had experienced any dizziness, nausea, vomiting, fatigue, chills, shaking, muscle weakness, skin flushing, itching, or diarrhea, if there was a thrill and bruit noted, and a place to enter access site notes. On [DATE], the TAR signed by registered nurse (RN)-A stating the pre-and-post dialysis assessment was completed but an assessment was not completed. The TAR was signed off that the assessment was completed every Monday, Wednesday, and Friday except for when R1 was in the hospital from [DATE] through [DATE] and from [DATE] to [DATE]. The pre-and-post dialysis assessment had only been completed on [DATE], [DATE], and [DATE] during his admission. R1's hospital records indicated R1 was admitted to the hospital from [DATE] to [DATE] after a witnessed fall. R1's admitting diagnosis was a fall including closed fracture of proximal end of right ulna, laceration of left lower extremity, hypomagnesemia, hypophosphatemia, acute hypokalemia, cardiac pacemaker, dysphagia, end stage renal disease, closed fracture of right olecranon process, hypotension, malnutrition, hypovolemia, and anemia. Assessments indicated R1 had crackle/coarse and expiratory wheezes in all lobes of R1's lungs. During R1's hospitalization , respiratory therapy administered R1's nebulizer and performed chest physiotherapy. The discharge exam on [DATE] indicated R1 had coarse bilateral lung sounds in all lobes of the lungs. It was noted R1 should continue with his vest therapy and saline nebulizers and DuoNebs as ordered. R1's Admission/Readmission and Care Plan Nursing assessment dated [DATE] indicated R1 was not on a nebulizer, R1 did not have oxygen needs, and R1 had normal lung sounds. R1's progress note written by the nurse manager (NM) on [DATE] at 4:58 p.m. indicated R1 did not have any respiratory devices. R1's vital signs documented on [DATE] at 2:01 p.m. indicated R1's oxygen was ninety-six percent while R1 was on oxygen via nasal cannula, blood pressure was one hundred twenty over seventy-four mmHg while lying and blood pressure was taken on right arm, pain score was five, pulse was seventy beats per minute, and lungs were clear. R1's temperature and respirations were not taken at this time. R1's hospital discharge record dated [DATE] indicated R1 was transferred from the dialysis clinic to the hospital due at 12:52 p.m. due to hypotension and shortness of breath. Hospital records indicated R1 was admitted to the hospital due to acute respiratory failure with hypoxia, COPD exacerbation, and pneumonia of left lower lobe due to infectious organism. The hospital records indicated R1 had bilateral significant wheezing, crackles, and had coarse sounds in his lungs that had been brewing for a few days. Hospital records indicated R1 had severe sepsis from community acquired pneumonia, COPD, and aspiration pneumonitis. Hospital records indicated R1 was transferred to the intensive care unit (ICU). Hospital records indicated R1 continued to have increased oxygen requirements, was altered, unresponsive to questions, and unable to tolerate secretions. Hospital records indicated R1 died on [DATE] due to severe sepsis with shock, pneumonia of left lower lobe due to infectious organism, and acute hypoxic respiratory failure. ' (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's vital signs documentation indicated R1's vital signs were taking on [DATE] at 2:01 p.m. R1's blood pressure was one hundred twenty over seventy-four, oxygen was ninety-six percent on oxygen via nasal cannula, pain was scored at five, and pulse was seventy beats per minute. R1's temperature and respirations were not documented. During an interview with nursing assistant (NA)-B on [DATE] at 12:32 p.m., NA-B stated R1 did not have respiratory problems during his admission at the facility. During an interview with registered nurse (RN)-A on [DATE] at 12:49 p.m., RN-A stated he was R1's nurse on [DATE] and R1 had gone to dialysis that morning. Then on [DATE] at 2:48 p.m., RN-A stated he believed he had taken R1's vital signs on [DATE] but could not remember what the vital sign readings were. RN-A stated from what he remembered, R1 had been a little more tired than his baseline, but that his appearance was nothing out of the ordinary. RN-A stated he does not remember R1's lungs being wheezy on [DATE]. On [DATE] at 3:00 p.m., RN-A stated he did not see any concerns with R1 leaving for dialysis on [DATE]. During an interview with the NM on [DATE] at 12:59 p.m., the NM stated R1's dialysis center called him and left a voicemail from the DN stating R1 was having shortness of breath and the dialysis center sent R1 to the hospital and directed him to follow up with the hospital. The NM stated R1 never complained of shortness of breath to him. The NM stated R1 was on continuous oxygen, and he was compliant with his oxygen use. During an interview with R1's guardian on [DATE] at 1:09 p.m., the guardian stated R1 had issues with his lungs where he would not cough up his mucous. During an interview with the dialysis nurse (DN) on [DATE] at 9:13 a.m. indicated R1 came to the dialysis center on [DATE] with labored breathing. DN stated she sent R1 to the emergency department via ambulance due to his labored breathing. It is unknown if the dialysis clinic started R1's dialysis. An interview was attempted with the dialysis center on [DATE] at 2:31 p.m., 3:17 p.m., [DATE] at 9:20 a.m., 10:07 a.m., and 3:35 p.m., but the phone kept ringing and was unable to leave a voicemail. During an interview with NA-C on [DATE] at 3:06 p.m., NA-C stated she did not remember R1 wheezing on [DATE]. NA-C stated he looked very tired on [DATE]. NA-C stated she did not remember what R1's appearance looked on [DATE] because she was not focused on R1's appearance. During an interview with the DON on [DATE] at 3:37 p.m., the DON stated the facility assessed R1's lung and respiratory status on [DATE] and his lungs were clear. During an interview with licensed practical nurse (LPN)-A on [DATE] at 2:15 p.m., LPN-A stated she worked with R1 on [DATE] but could not tell the writer what R1's condition was that day. LPN-A stated she did not know R1's baseline due to her being newly employed by the facility. LPN-A stated she did not think she had any concerns with R1 on [DATE]. LPN-A stated if she did have concerns with R1 on [DATE] she would have called and reported it to the physician and she does not recall having to contact the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlyn Heights Healthcare Center	2060 Upper 55th Street East Inver Grove Heights, MN 55077

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the administrator on [DATE] at 4:09 p.m., the administrator stated it is his expectation that orders are followed exactly how they are written in a resident's chart.