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	12/05/2024

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 0570 Level of Harm - Potential for minimal harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 49034 Based on interview and document review, the facility failed to ensure resident personal fund accounts were insured with adequate surety bond coverage (a contract or promise by a surety or guarantor to pay a certain amount if a second party fails to meet the obligation) to cover the total account balance. This had potential to affect 20 residents identified to have an account with a positive balance. Findings include: The undated facility provided resident fund account record, received on 12/3/24, identified 20 residents who had current fund accounts with a positive balance. The total amount of these accounts was recorded as $27, 953.42. A Continuation Certificate dated 4/2/24, indicated the facility had a surety bond in place for up to $25,000.00. During an interview on 12/4/24 at 12:08 p.m., the administrator acknowledged the surety bond would not fully cover the resident's personal fund accounts. The administrator stated cooperate oversaw the surety bond and he would reach out to see if they had an updated version. Evidence of an updated surety bond was not received. The facility Resident Trust Funds policy dated 12/23, indicated a surety bond would be purchased by Home Office for each facility, which would ensure the security of all resident trust funds deposited into the account.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 33925

Based on observation, interview, and document review, the facility failed to assess potential signs of constipation to determine what, if any, interventions were needed to promote comfort and reduce the risk of complication (i.e., impaction) for 1 of 1 residents (R15); failed to comprehensively assess and develop interventions to ensure a consistent nursing approach with a developed, non-pressure skin condition for 1 of 2 (R5); and failed to ensure orders for a peripherally inserted central catheter (i.e. PICC line) were clarified and the line was managed in accordance with professional standards of care for 1 of 1 residents (R28) reviewed who had a PICC.

Findings include:

BOWEL MANAGEMENT:

R15's quarterly Minimum Data Set (MDS), dated [DATE], identified R15 had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS outlined R15 was totally incontinent of bowel and consumed multiple medications including both psychotropic and narcotic medications.

On 12/2/24 at 3:07 p.m., R15 was observed laying in bed while in her room. R15 was interviewed and expressed she felt constipated adding she had only been having a stool every other day when her normal pattern was daily. R15 stated nobody from the care center, at least to her recall, had visited with her or asked about constipation nor what, if any, interventions could help it (i.e., prune juice, medication adjustment). R15 stated she wished someone would though.

R15's care plan, printed 12/4/24, identified R15's current and potential issues or complications. The care plan identified R15 needed assistance of one for toileting and R15 was incontinent of bladder and bowel due to limited mobility and hospice-focused cares. The care plan listed interventions for this identified problem including barrier cream applied to her skin, observing for signs of a urinary tract infection (i.e., UTI), and peri-cares after incontinent. Further, the care plan identified R15 was at risk of dehydration due to constipation and listed two interventions for this including observing her skin integrity and, Observe/document bowel sounds and frequency of BM [bowel movement]: provide medication per order. The care plan lacked any further information on R15's constipation including what, if any, other interventions for it aside from medication administration were being done or had been discussed/used prior.

When interviewed on 12/4/24 at 9:01 a.m., nursing assistant (NA)-A stated they had worked with R15 and described her as having poor mobility adding, [She] stays in bed mostly all the time. NA-A stated R15 had incontinence of bladder and bowel but felt she was good at calling for someone to change her. NA-A stated residents' bowel movements were tracked in the point-of-care charting on their computer system, and staff could select the size of stool each time. NA-A stated they had last helped R15 with bowel incontinence about two weeks prior and, at that time, the stool didn't seem hard adding R15 had not reported any concerns about her bowels to them. NA-A stated if a resident complained about constipation, then it was the nurses' job to address it adding, They handle it.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's POC (Point of Care) Response History, printed 12/4/24, identified a 14 day look-back period and recorded R15's bowel movements. A labeled field reading, Size of BM, was listed which provided a check mark on the corresponding size of stool (i.e., small, large) for each date R15 had one recorded. This information identified the following: 11/23/24 - R15 had one large BM recorded. 11/24/24 - R15 had one small BM recorded. 11/25/24 to 11/27/24 (three days) - R15 had no BM recorded. 11/28/24 - R15 had one large BM recorded. 11/29/24 - R15 had one medium BM recorded. 11/30/24 - R15 had one large BM recorded. 12/1/24 to 12/2/24 (two days) - R15 had no BM recorded with dictation, Response Not Required. 12/3/24 - R15 had one large BM recorded. R15's medical record was reviewed and lacked evidence R15's bowel patterns (i.e., multiple days without one, no staff data) had been identified or evaluated to determine what, if any, interventions were needed to promote more regular bowel movements and reduce the risk of complication despite R15 consuming narcotic medications, having a history of constipation as identified on the care plan, and going multiple day periods without a stool. Further, R15's medical record contained multiple previous assessments labeled, Continence Evaluation, however, the last completed or recorded one was dated 12/2022 (two years prior). When interviewed on 12/4/24 at 10:22 a.m., registered nurse (RN)-A stated the night shift nurse typically pulled a report and would tell the morning shift nurse what residents were on multiple days without a bowel movement. RN-A stated the morning nurse would then follow-up, if needed, and could use the facility' standing orders to address it. RN-A stated R15 was already on some scheduled bowel medications, such as Senna and Miralax, adding the nurse manager would help oversee assessments and complete them, if needed. RN-A verified the NA staff use only the POC charting to record bowel movements. On 12/5/24 at 10:16 a.m., the director of nursing (DON) and registered nurse unit manager (RN)-C were interviewed. DON verified they had reviewed R15's medical record and explained bowel status should be evaluated upon admission, quarterly and when warranted. DON stated this was done using the Continence Evaluation, however, one had not been completed for several years adding, It has not been done. DON verified there was no documented evidence to show R15's bowel status had been evaluated and expressed it should be done adding aloud, That is the expectation. DON stated the NA staff use the POC to document residents' bowel movements and, upon reviewing R15's charting, it seemed the aides were not documenting well and recording incontinence but no bowel movement adding there was room for education on appropriate documentation. DON stated it was important to ensure bowel status was assessed due to the high risk of constipation for R15. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility' policy on bowel status assessment or evaluation was requested, however, none was received. 47495 Non-Pressure Skin Condition R5's admission Minimum Data Set (MDS), dated [DATE], indicated R5 was admitted to the care facility on 10/4/24, was cognitively intact and required substantial/maximum assistance with bathing and lower body dressing and partial assistance with upper body dressing. R5's Hospital History and Physical (H&P), dated 9/25/24, indicated R5 had a past medical history of Darier [NAME] disease (a rare genetic skin condition that causes a number of symptoms, including wart-like bumps that are hard, greasy, and yellowish in color. They can be itchy, weepy, or raw. The lesions can appear on the scalp, forehead, upper arms, chest, back, knees, elbows, and behind the ears. They can also appear in skin folds, like under the breasts or in the groin area) complicated by recurrent wounds and cellulitis. The H&P indicated R5 was hospitalized at that time with worsening of chronic skin wounds, indicating visible skin from head to arms cracked and dry with sloughing and wounds in various stages of healing. R5's Orders, printed 12/5/24, indicated R5 had the following orders related to her Darier [NAME] disease: Wound Care 1. Avoid debridement of skin 2. OK to substitute dilute bleach baths with hydrogen peroxide skin soap, will defer to patient preference. 3. Recommend after cleansing, patient rinse and PAT DRY GENTLY, no rubbing or scrubbing or debriding skin 4. Apply emollients to include betamethasone-clotrimazole, mupirocin and Aquaphor to affected skin. Important to apply barrier repair immediately (within 2-3 mins after bathing) every day shift every Mon[day], Wed[day], Fri[day] and Okay to use stockinette vest after wound and rash treatment. Vest should wash and reuse. Wound care was scheduled for day shift despite R5's showers scheduled for evening shift per her preference. R5's Orders, dated 12/5/24, also indicated the following topical ointment orders: Mupirocin External Ointment 2%; apply to skin topically two times a day for skin care, Emollient External Ointment; apply to skin typically four times a day for skin care, and Clotrimazole External Cream 1%; apply to affected skin area topically two times a day for Darier [NAME] Disease. In addition, R5's Orders, dated 12/5/24, indicated the following oral medications: Seroquel (medication to treat anxiety) Oral Tablet 25 milligrams (mg); give 1 tablet by mouth every 6 hours as needed for anxiety for 14 days, Hydroxyzine Oral Tablet 50mg; give 1 tablet by mouth every 4 hours as needed for anxiety for 14 days, and Oxycodone Oral Tablet; give 10mg by mouth every 4 hours as needed for pain may give 1-1.5 tablets (10mg - 15mg) AND give 15 mg by mouth every 4 hours as needed for pain 6-10. R5's Care Plan, dated 10/4/24, indicated R5 had potential/actual impairment to skin integrity r/t [related to] decreased mobility, incontinence, and Darier [NAME] Disease. Interventions included keep linens dry, wrinkle free, keep skin clean and dry. Apply lotion to dry skin during cares. DO not apply lotion between toes or to open, rashy areas, and observe skin during care. Report changes to nurse. However, R5's Care Plan lacked any specific interventions related to her Darier [NAME] Disease. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Medication (and treatment) Administration Record (MAR), dated 11/1/24 - 11/30/24, indicated R5 received wound care to her skin 6 times on 11/8/24, 11/15/24, 11/18/24, 11/20/24, 11/25/24, and 11/29/24. The MAR indicated R5 did not receive wound care to her skin due to refused or other/see progress note 6 times on 11/4/24, 11/5/24, 11/11/24, 11/13/24, 11/22/24, and 11/27/24. R5's MAR, dated 12/1/24 - 12/5/24, indicated R5 did not receive any wound care to her skin due to other/see progress note on 12/2/24 and 12/4/24. R5's Progress Notes, dated 10/4/24 - 12/5/24, lacked an explanation of why wound care was not provided on 11/22/24 and 12/4/24 despite the MAR indicating to see progress note. On 12/2/24 it was documented resident refused wound care and treatment creams. Did fall back to sleep til 1130 am after taking AM morning meds. Writer offered and asked resident if she wanted to get wound done couples of times. Resident stated wanted to take a shower before wound get done. Residents left downstairs for some time. Wirer followed her on 2nd floor and asked if still wanted wound to get done before shift end. Kept pushing til the end of shift and was unable to do it. Reported to evening RN [registered nurse] to follow up. During an interview and observation on 12/2/24 at 3:30 p.m., R5 stated she sat in dirty bandages for 5-6 days when she was first admitted and had concerns about her wound care still not getting done properly, stating she had been doing her wound care for 9 years due to her Darier [NAME] Disease and it required ABD pads, stockinettes, and a 14-ounce jar of Aquaphor with each dressing change since her skin was effected from head to toe. R5's entire skin from head to toe was dry and flaking with denuded areas that were red and shiny in appearance. R5 stated she was supposed to use a vest made of a soft mesh material to hold the abd pads in place on her chest and back, however the facility had not supplied her with the vest and so the skin on her torso was open to air, causing her pain and her skin to weep onto her clothing which caused yellow staining of her clothes. R5 stated she would always need to shower before her wound care to help remove the old dressings and to prevent and remove keratin build up on her skin, stating when she didn't get frequent showers it would cause worsening of her skin breakdown. However, R5 stated without the correct amount of Aquaphor and supplies, she could not shower because of how painful the air was to her skin, stating the facility was also unable to provide her with the needed amount of Aquaphor, the correct stockinettes or the mesh vest that would hold the ABDs in place. R5 stated at her last care conference, on 11/20/24, they scheduled her showers for Monday, Wednesday, and Friday evenings because she preferred to sleep in late, but that due to supply and scheduling issues she was not getting wound care as needed which caused her bandages to have a foul odor and her clothes to have yellow staining. R5 stated, I shouldn't have to feel that undignified, that belittled when other residents tell her that her bandages have a foul odor. During an interview on 12/4/24 at 8:41a.m., nursing assistant (NA)-F stated she does not help with R5's wound care but helps a lot with her showers, stating after her showers she gets ointment over her whole body. NA-F stated she did not believe that R5 refused her showers but that the showers were painful for R5 due to her skin condition and raw, open skin, that at times R5 just felt like she needed to wait to shower. NA-F further stated when R5 was admitted to the care facility, they did not have the supplies she needed for about a month, stating she believed R5 had everything she needed now but could not be 100% sure. NA-F also confirmed R5 had a lot of weeping from her skin which caused her and her room to have an odor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/4/24 at 10:08 a.m., registered nurse (RN)-H stated she believed R5 was supposed to receive a shower three times a day, during the day shift, stating R5 would postpone and postpone her shower until the end of her shift and it would frequently get missed. RN-H further stated R5 was in pain and bleeding during her showers and that staff try to give her PRN Hydroxyzine, Seroquel and Oxycodone prior to her showers. RN-H stated R5 would use her Aquaphor all over her body, her other ointments (Clotrimazole and Mupirocin) were only used to spot treat any open areas on her skin and a mesh body suit over her ointments with no other dressings (i.e. ABD pads) between her skin and the mesh body suit. RN-H also stated R5's skin was very weepy and would often leak a yellow substance through her clothes creating an odor on the bandages. During an interview, nurse manager and RN-D stated R5 did not come with an order that specified how much Aquaphor she should use, stating a 14 once jar was excessive, however confirming she did use it to cover her entire body. RN-D stated he received an order from the nurse practitioner to use a mesh vest and stockinettes, however they were not able to get a mesh vest for R5 to use and R5 had just received the appropriate size stockinettes on 12/2/24 at approximately 9:30 p.m. RN-D stated R5 was supposed to receive PRN Oxycodone, Seroquel and Hydroxyzine prior to a shower but confirmed the order did not specify that. RN-D further confirmed that while he supplied the ABDs for R5's wound care, the order in her chart did not specify to use the ABDs because she was not admitted to the care facility with the order and the ABDs were only R5's preference. RN-D confirmed the orders did not specify how staff were supposed to use R5's 3 ointments (Aquaphor, Clotrimazole and Mupirocin), but he believed they should all be mixed together and then applied to her skin. RN-D stated R5 did refuse showers a lot but was unable to confirm any comprehensive assessment or reassessment that had been done to determine what R5 needed for her showers and wound care, when she wanted them done, risks vs benefits or refusing and/or why she was refusing her showers and wound care. During an interview on 12/4/24 at 12:45 p.m., R5 stated she had finally received the correct size stockinettes late Monday night. R5 further stated she needed to keep up with her three times a week showers, stating she did not want to refuse them but when she did not have the right supplies she could not shower. R5 stated she could not take her old bandages off, shower and have nothing to put on her skin as it would be too painful causing her to feel forced to keep dirty bandages on. R5 stated she was concerned about still not having a mesh vest to wear which would allow her to cover her chest and back with the appropriate ABDs. R5 further stated was about to run out of Aquaphor sating, I don't know what I am going to do when that happens, I can't afford it on my own. R5 stated she was worried she would end up in the hospital again without the correct supplies to manage her skin properly. During an interview on 12/5/24 at 10:33 a.m., RN-G stated R5's showers were all over the place and sometime NA-F would do it during the day, so it was not clear when her scheduled shower times were. NA-C confirmed R5 should be getting showers in the evenings since R5 preferred to sleep in late in the mornings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/24 at 11:41 a.m., the director of nursing (DON) confirmed that the showers and wound care for R5 were not clear, stating it was because the wound care process R5 wanted was a preference and not an order. The DON stated they tried to work with R5 but was unable to show documentation of a comprehensive assessment or reassessment of R5's wounds/wound care, refusals, or risk versus benefits. The DON further stated the Aquaphor and mesh vest was not covered by R5's insurance, however lacked evidence staff worked with R5 and/or her provider to find an agreeable alternative or to attempt to get it covered. The DON stated she did not believe R5 needed a whole tub of Aquaphor despite R5 needing it to protect her skin on her entire body after every shower. 48065 PICC DRESSING: R28's quarterly Minimal Data Set (MDS) dated [DATE], indicated R28 was cognitively intact, had no behaviors and did not refuse personal cares. The quarterly MDS indicated R28 needed maximal assistance with showers, dressing, toileting and was dependent with all aspect of mobility. R28's Clinical Diagnosis report printed 12/5/24, indicated diagnoses of multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), pressure areas (an injury to the skin and underlying tissue resulting for prolonged pressure on the skin), neurogenic bladder, (lack of bladder control due to spine or nerve injuries) , constipation, epilepsy (brain disorder that causes recurring, unprovoked involuntary movement), quadriplegia (paralysis that affects all a person ' s limbs and body from the neck down), and colostomy (a surgical procedure that creates an opening in the abdomen to divert stool from the colon to a bag or pouch). R28's Clinical Orders report printed 12/4/24, indicated an order dated 11/20/24 for vancomycin HCL intravenous (IV) solution (antibiotic medication) 1250 milligrams (mg)/250 milliliters (ml) for methicillin-resistant staphylococcus aureus (a bacterial infecion also called MRSA) infection. R28's orders report lacked orders to change the peripherally inserted central catheter (PICC) line dressing, and/or monitoring insertion site for signs and symptoms of infection. R28's Care Plan indicated printed on 12/4/24 indicated R28 had MRSA which required antibiotic therapy. R28's care plan lacked documentation regarding the PICC line and the IV therapy. R28's medication administration record (MAR) and the treatment administration record (TAR) for the months of November and December lacked documentation regarding changing the PICC line dressing and/or monitoring the insertion site for signs and symptoms of infection. R28's progress note dated 11/20/24 at 5:09 a.m. indicated R28 had a PICC inserted in the right upper arm. During observation and interview on 12/4/24 at 10:15 a.m., registered nurse (RN)-F started R28's vancomycin IV infusion via PICC line. R28's PICC line was on the right upper arm. The insertion site was covered with a clear dressing without a date indicating when the dressing was changed. R28 stated nobody has changed the dressing since it was inserted on 11/20/24. RN-F verified the PICC line dressing was separated from the skin around three out of the four sides of the dressing and lacked a date when the dressing was changed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 12/4/24 at 10:43 a.m., RN-F verified there were no orders to change the PICC line dressing and/or to monitor insertion the site for signs and symptoms for infection. RN-F stated the nurse manager was responsible to make sure the orders were added to the medication administration record (MAR) and the treatment administration record (TAR). During interview on 12/4/24 at 10:56 a.m., nurse manager, RN-C stated R28 had a PICC line and the PICC line cap and dressing needed to be changed every seven days. RN-C stated when a resident had a PICC line, the nurse manager would add it to the medical record including the orders, MAR and TAR. In addition, the TAR would include the orders to care for the PICC line and to observe the PICC line site for signs or symptoms of infection. RN-C stated any nurse could also enter those orders. RN-C reviewed R28's medical record and verified the lack of orders and/or documentation about changing the PICC line dressing. During interview on 12/5/24 at 9:20 a.m., director of nursing (DON) stated a PICC line dressing needed to be changed every seven days. DON stated if a dressing is not changed it could lead to an infection. A facility's policy on PICC line care was requested, however, none was received.