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	12/31/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide adequate nursing staff to meet assessed resident needs for 1 of 1 residents (R29) reviewed for restorative nursing; 1 of 1 residents (R43) reviewed for activities of daily living (ADLs); and 12 residents (R3, R14, R18, R29, R82, R33, R39, R5, R44, R57, R67, R74) and 3 staff members (NA-F, NA-E, NA-H) who voiced concerns with a lack of staffing. The lack of sufficient nursing staffing had the potential to affect all 46 residents in the facility. Findings include:RESTORATIVE PROGRAM:R29's quarterly Minimum Data Set (MDS) dated [DATE], indicated R29 had intact cognition with no rejection of care behaviors during the look-back period (LBP). The MDS indicated R29 had impaired ROM on both lower extremities. The MDS indicated R29 required maximum assistance with bed mobility and lower body dressing. R29's Therapy Referral for Maintenance Program dated 10/24/24, indicated that physical therapy recommended staff assist R29 with passive ROM to bilateral hips, knees, and ankles daily. R29's care plan dated 8/10/25, indicated R29 was to receive passive ROM to the bilateral hips, knees, and ankles daily. R29's task list dated 11/30/25 to 12/28/25, indicated that staff were to complete passive ROM on R29's bilateral hips, knees, and ankles daily. The report indicated the task had been refused five times, completed 17 times, charted as not applicable five times (with no further entry indicating it was completed or refused that day), and had no entry on 12/7/25, 12/19/25, and 12/20/25. During an interview on 12/29/25 at 3:37 p.m., R29 stated that staff were supposed to complete ROM with her daily, but never do it. During an interview on 12/31/25 at 8:46 a.m., nursing assistant (NA)-D stated she had worked with R29 in the past, and she would rarely refuse to complete ROM when she had time to complete it with R29. NA-D stated she often didn't feel like she had enough time to complete everything she had to do during her shift, so she often did not complete ROM when she worked with her as a result. During an interview on 12/31/25 at 9:18 a.m. with NA-B and NA-C, NA-B stated it was often hard to complete everything they needed to do during their shift. NA-B stated that if they had time to do ROM, they would, but it often didn't get done. NA-B stated that if they did complete ROM with R29, they would chart it as completed on her tasks list. During an interview on 12/31/25 at 9:10 a.m., the director of nursing (DON) stated that if a resident needed ROM, it would be added to tasks where staff could document if it was completed or not. The DON stated that after reviewing R29's medical record, staff should be completing ROM with her daily. The DON stated the NAs had notified her that they were having a hard time finding enough time to complete ROM, so the facility was looking to get a restorative aide to assist, but it had not yet happened. ADLS NOT COMPLETED:R43R43's admission Minimum Data Set (MDS), dated [DATE], identified R43 had intact cognition and required full assistance with personal hygiene cares. R43 had diagnoses of respiratory failure, muscle weakness, malignant neoplasm of left breast and chronic pain.R43's care plan, dated 11/14/25, identified R43 had an ADL self-care deficient with grooming, and required assistance of one by staff.R43's weekly body audit, dated 12/24/25, identified R43 finger and toenails were not cleaned or trimmed.During observation and interview on 12/29/25 at 3:42 p.m., R43 stated her nails were long and dirty. She stated requested an unknown staff member to (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	have them cleaned and trimmed, but it was not performed. R43's fingernails were observed, nails were approximately 1/4 inch long, with brown substance under nails. Her toenails were approximately 1/4 inch long and no sign of discolored substance under them.During observation and interview on 12/30/25 at 11:24 a.m., R43 stated that nails were not cut or cleaned by staff. However, family member (FM)-G trimmed right thumb and pointer finger.During interview on 12/30/25 at 2:54 p.m., nursing assistant (NA)-I stated R43's nails were not clean or trimmed on both hands, except for pointer finger and thumb on right hand. NA-I stated nail care was usually done on bath/shower days.During interview with director of nursing (DON)-B stated the expectation for nail care was to be completed on bath/shower days and as needed. If a resident asked to have nails cleaned and trimmed it was expected for staff to perform that function. Nail care was important for hygiene and overall skin integrity.R44R44's quarterly Minimum Data Set (MDS) assessment, dated 11/18/15, identified R44 had intact cognition with no hallucinations or delusions, behaviors or rejection of care. MDS indicated R44 needed moderated assisted for personal hygiene which included shaving.During an interview on 12/29/25 at 1:46 p.m., R44 stated that he does not like to have any facial hair as it becomes very itchy. R44 stated he has told staff this previously. R44 stated the staff only shave him on showers days but his preference would be to be shaved daily with morning cares. R44 was observed to have approximately a quarter in beard and mustache.During an interview on 12/30/25 at 11:21 a.m., R44 was observed in his room and observed to continue to have unshaven facial hair. Two nursing assistants came in after surveyor entered to see why R44's call light was on, so surveyor ended the interview to they could assist him.R44's care plan, printed 12/31/25, identified R9 has an ADL self-care performance deficient related to limited mobility and musculoskeletal impairment and requires assistance with dressing/undressing and requires 1 staff assistance to use toilet.R44's care plan lacked identification of level of assistance R44 needs for personal hygiene such as shaving or showers.R44's Tub/Shower Transfer log, printed 12/31/25, indicated R44 last shower was 12/23/25 and required maximal assistance.R44's progress notes, dated 12/1/25 to 12/31/25, were reviewed. The progress notes lacked evidence that R44 was offered and refused to be shaved. During an interview on 12/30/25 at 1:55 p.m., nursing assistant (NA)-E stated they listen to what residents want when completing morning cares. NA-E verified they are familiar with R44 and completed morning cares with R44. NA-E stated R44 needs assist of 1 with cares and assist of 2 with transfers. NA-E stated they have not shaved R44 facial hair today, stating sometimes I am not able to get to the small stuff. I can't get to it all. NA-E verified that had facial hair that could be shaved.During an interview on 12/30/25 at 2:04 p.m., registered nurse (RN)-B stated morning cares should include washing a resident's face, underarms, peri-area, changing clothes, oral cares and shaving. RN-B stated typically, shaving is done on showers done but we can shave a resident anytime. RN-B stated any nursing staff should be asking a resident preference every step of the way when getting them ready in the morning or at night.During an interview on 12/31/25 at 10:27 a.m., R44 was observed to continue to have unshaven facial hair. R44 stated, it's still growing, and getting real itchy. During an interview on 12/31/25 at 10:37 a.m., NA-F stated shaving should be offered with morning cares. NA-F stated it appears that R44 hasn't been shaved for about 5-7 days based on the length of the facial hair. NA-F verified R44 has a razor in his bathroom. During an interview on 12/31/25 at 10:47 a.m., NA-F stated morning cares should include the following: washing face, hands, underarms, peri-area, combing hair, shaving, brushing teeth, changing clothes. NA-F stated they assisted R44 today with morning cares. NA-F stated they did not shave R44 or offer to shave R44 as it takes him a long time to brush his teeth and I have to multitask. NA-F stated they would shave R44's facial hair and stated it should have been done with morning cares. During an interview on 12/31/25 at 11:36 a.m., director of nursing (DON) stated the expectation would be a resident's facial would be done with bathing and as needed when staff notice that it is growing per resident's preference. RESIDENT CONCERNS WITH LACK OF STAFFING:R3's admission Minimum Data Set (MDS) assessment dated [DATE], identified R3 had intact cognition. During an interview on 12/29/25 at 2:10 p.m., R3 stated that some days they only (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	have one person in the evening, and they take a long time to answer the call light. R3 stated he will wait 45 minutes to an hour.R3's Device Activity Report, from 12/1/25 to 12/30/25, identified the following information:-longest response time was 124 minutes and 11 seconds (2 hours 4 minutes)-40 call lights response times over 15 minutesR29's quarterly MDS assessment dated [DATE], identified R29 had intact cognition. During an interview on 12/29/25 at 3:29 p.m., R29 stated they are always short and things they don't change her at night due to staffing.R29's Device Activity Report, from 12/1/25 to 12/30/25, identified the following information:-longest response time was 119 minutes and 58 seconds-95 call lights response times over 15 minutesR82's tracking MDS indicated R82 was admitted to the facility on [DATE]. admission MDS not completed at this time. During an interview on 12/29/25 at 1:23 pm., R82 stated sometimes I must wait and wait, and I dribble. R82 stated, I used the urinal but sometimes I get wet.A Device Activity Report for the month of December was requested and not received.R33's quarterly MDS assessment dated [DATE], identified R33 had intact cognition. During an interview on 12/29/25 at 2:54 p.m., R33 stated a couple of days ago it took one and half hours when he put the call light on for staff to come assist him to use the bathroom. R33 stated about 3 months ago it took 3 hours for staff to come and assist.R33's Device Activity Report, from 12/1/25 to 12/30/25, identified the following information:-longest response time was 145 minutes and 21 seconds (2 hours 25 minutes)-136 call lights response times over 15 minutesR39's significant change of condition MDS assessment dated [DATE], identified R39 had intact cognition. During an interview on 12/29/25 at 4:49 p.m., R39 stated she will wait upwards 3 hours after she pushes her call light for staff assistance. R39 stated she needs staff assistance with any transfers as she uses a lift to transfer.R39's Device Activity Report, from 12/1/25 to 12/30/25, identified the following information:-longest response time was 101 minutes and 20 seconds (1 hour and 41 minutes)-43 call lights response times over 15 minutesR5's quarterly MDS assessment dated [DATE], identified R5 had intact cognition. During an interview on 12/29/25 at 4:41 p.m., R5 stated when she pushes the call light it takes about 45 minutes for assistance. R5 stated she needs assistance with all transfers.R5's Device Activity Report, from 12/1/25 to 12/30/25, identified the following information:-longest response time was 128 minutes and 11 seconds (2 hours 8 minutes)-82 call lights response times over 15 minutesR44's quarterly MDS assessment dated [DATE], identified R44 had intact cognition. During an interview on 12/29/25 at 1:33 p.m., R44 stated he needs staff assistance for many things such as transfers, going to the bathroom, sometimes grabbing items. R44 stated that he will push the call light and he will be waiting 30 minutes at least.A Device Activity Report for the month of December was requested and not received.R57's annual MDS assessment dated [DATE], identified R57 had moderately impaired cognition. During an interview on 12/29/25 at 12:37 p.m., R57 stated it will sometimes take over an hour for staff to respond when you put the call light. R57 stated she needs assistance to use the bathroom, for medications, and to transfer from one chair to another.R57's Device Activity Report, from 12/1/25 to 12/30/25, identified the following information:-longest response time was 99 minutes and 13 seconds (1 hour 39 minutes)-28 call lights response times over 15 minutesR67's admission MDS assessment dated [DATE], identified R67 had moderately impaired cognition. During an interview on 12/29/25 at 4:09 p.m., R67 stated sometimes he waits a long time to get his call light answered.R67's Device Activity Report, from 12/4/25 to 12/30/25, identified the following information:-longest response time was 24 minutes and 6 seconds-8 call lights response times over 15 minutesR37's quarterly MDS dated [DATE], identified R37 had intact cognition. During an observation on 12/31/25 at 8:35 a.m., the call light screen was observed that R37's call light had been on since 7:56 a.m. (39 minutes). At 8:38 a.m., R37 was observed lying in bed. R37 stated she was waiting for staff to come and assist her. R37 stated she was waiting for some ice water and thinks she might need to be changed as her underwear may be wet. At 8:43 a.m., a nursing assistant was observed to go in R37's to see what R37 needed (47 minutes after call light had been put on for assistance). Nursing assistant was observed to bring R37 water and ask her if she wanted to get up which R37 declined.During resident council interview on (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12/31/25 at 12:30 p.m., R14, R18 and R74 all stated when they turn their call lights on for help, staff will come into their room and turn off the call light without asking or addressing their needs. R74 stated her brief is soaked with urine by morning because staff are not coming in to help her because they are always short staffed. R74 stated staff are so busy that she often takes herself to the bathroom, even though she is not supposed to. R81 added that she often waits hours overnight for her brief to be changed and it makes her feel like I [R81] want to pack up leave. STAFF CONCERNS WITH LACK OF STAFFING:During an interview on 12/30/25 at 11:42 a.m., nursing assistant (NA)-F stated that there was not enough staff to complete the work. NA-F stated one aid per hallway was not enough as that was 12-14 residents per aid. NA-F stated they are not able to complete showers or range of motion for resident. NA-F stated they are not able to meet residents needs and it is too much.During an interview on 12/30/25 at 1:55 p.m., NA-E stated the workload was not manageable. NA-E stated the first two hours of their shift, they are doing laundry as the residents' beds are full of piss and BM. NA-E stated the nightshift put sheets over the soiled sheets to cover it up. NA-E stated they have reported this to the administrator, director of nursing and staffing. NA-E stated residents will wait for staff to help them and call lights will be on hours. NA-E stated they are not able to get residents cares done such as shaving due to the workload adding I can't get to it all, and I don't get breaks. During an interview on 12/31/25 at 8:46 a.m., NA-H stated nursing assistants try to get to the call lights as soon as possible. NA-H stated, we don't have enough time to do showers, range of motion or walking and shaving is hard to get done. NA-H stated there wasn't a specific amount time that call lights are to be answered, just the first light on is supposed to be the first light answered. NA-H stated they feel the residents' needs are affected by not having enough staff as things can't always be done.During an interview on 12/31/25 at 11:46 a.m., director of nursing (DON) stated staffing is based on census and resident needs. DON stated the expectation was to answer call lights as soon as you are able and would like to keep it under the 15-minute mark. DON reviewed call light log and stated the longer call lights are not acceptable. DON stated she had been told by staff that they are not able to complete their work and care for the residents.During an interview on 12/31/25 at 11:51 a.m., assistant director of nursing (ADON) stated that at times staff forget to turn the call lights off after helping a resident. ADON stated this happens on occasion. ADON acknowledged that they had heard staff were not able to complete their work.During an interview on 12/31/25 at 12:03 p.m., executive director (ED) stated staff levels have typically been at or above recommended HPPD (hour per patient day). ED stated she had not been told specifically that staff are not able to complete their work. ED stated she had worked with staff on completing documentation which had increased. ED stated the expectation was all staff answer call lights, to be answered in the order they are pressed and has provided education to residents and staff to keep the call lights on the walls as when they are removed and carried around the facility this can lead to difficulty finding the resident when the call light was pressed and longer call light response times.A facility policy titled Nursing Services and Sufficient Staff, updated 2/23/25, indicated The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived, licensed nurses; and Other nursing personnel, including but not limited to nurse aides.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to perform adequate testing, per the manufacturer's instructions, to ensure proper sanitization of dishware used for meal preparation and meal service when using a low-temperature dishwashing machine. This had the potential to affect all 65 residents residing in the facility. Findings include: The National Sanitation Foundation (NSF) Data Plate for dishwasher Model ADC-44 dated 12/1/11, indicated that if the dishwasher was utilizing chemical sanitizer, the sanitizer required was 50 parts per million (PPM) of available Chlorine.An undated Ecolab Chlorine Test Paper (ECTP) instruction card, indicated that to test for PPM of free available chlorine, the strip should be dipped into the solution and immediately compared to the color chart. The card did not include an expiration date.The Hydrion Papers QT-10 (PPQT-10) instruction card dated 8/1/14, indicated they were used for the testing of n-alkyl dimethyl benzyl and/or n-alkyl dimethyl ethyl benzyl ammonium chloride. The card included an expiration date of 8/1/14. The card indicated the paper should be dipped in quat solution for 10 seconds, and the color should be compared at once. The instructions indicated that the testing solution should be at 75 degrees, should have a neutral pH, and the manufacturer's instructions for dilution should be followed carefully. The Hydrion Chlorine (HC) instruction card dated 2/1/26, indicated the paper was to be dipped and removed quickly. The user was then to immediately blot with a paper towel and compare to the color chart at once. The card had an expiration date of 2/1/26. During an observation and interview on 12/31/25 at 9:57 a.m., dietary aide (DA)-A was observed filling a hard plastic rack with serving utensils, taking an ECTP test paper, and placing it in the rack. DA-A was then observed placing the rack in the Model ADC-44 chemical sanitizing single rack dishwashing machine. The rack was observed to exit the other side of the machine, but DA-A was unable to locate the test paper. DA-A was then observed to take the rack back to the other side of the machine, place another ECTP test paper on the rack, and run it through the machine again. DA-A was able to locate the test paper, but on observation, the test strip was clear. DA-A stated she always used these strips but had not tested the machine yet today. DA-A confirmed her usual method for testing the chemical level of the sanitizer was sending it through the machine as observed above. DA-A confirmed she had completed most of the dishwashing from the previous meal already. DA-A stated she was not sure if the strips were defective and did not know if they had an expiration date. The dietary manager (DM) then provided the HC test papers. The DM placed a strip on the hard plastic rack and stated this was how they always tested the chemical level of the dishwasher, so she was unsure why they kept losing the strips. The DM then put a plate on a rack through the machine. The DM then took an HC test paper and left the paper in the water that had accumulated on the plate for about 30 seconds. The test paper was read at about 25 PPM. The DM stated she wasn't sure why these strips weren't working and confirmed that the HC test paper had not read at an acceptable level of sanitization. The DM was observed to come back with PPQT-10 test papers and was not observed to put the paper in the water but stated she had placed the test paper in the water for a few seconds. The DM stated the result was 300 to 400 PPM. The DM stated that this was an acceptable result and confirmed that no further testing was needed. The DM stated she would expect the PPM to reach at least 100, and either the PPQT-10 or the HC test papers were acceptable to use for the dishwasher. The facility Cleaning Dishes/Dish Machine policy dated 2021, indicated that proper chemical concentrations and machine function should be verified before machine use. The policy indicated that the sanitization level should reach 50 PPM.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. During observation and interview, the facility failed to implement interventions to ensure resident's personal care information was kept secured and out of public view when stored on a mobile medication cart in the long-term care unit. This had the potential to affect 11 residents (R7, R10, R12, R14, R15, R20, R31, R43, R55, R56, R60) whose personal information was left unattended on a medication cart in the hallway corridor. Findings include: During continuous observation on 12/30/25 at 10:42 a.m., to 11:04 a.m., there was an unattended care sheet on top of unattended medication cart. Care sheet was titled Nurse/TMA and had personal information on 11 residents of the long-term care unit. The care sheet included, name, room number, bath days, diets, hospice provider, and information regarding dialysis, urinary catheter use, and blood sugars. During continuous observation there were seventeen (17) instances where staff, residents, and visitors walked or were wheeled past the unattended care sheet.During interview with registered nurse (RN)-B on 12/30/25 at 11:04 a.m., RN-A approached the unattended medication cart and verified the unattended care sheet was his and it should not be left unattended. RN-B stated expectation of personal information to not be exposed.During interview with director of nursing (DON) on 12/30/25 at 11:07 a.m., DON stated expectation of staff to follow HIPAA and ensure personal information is not exposed or unattended.Facility policy titled Notice of Privacy Practices/HIPAA revised September 23, 2013 identified requirement to appropriately safeguard your information.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and document review, the facility failed to ensure resident rooms were maintained at a comfortable temperature between 71- and 81-degrees Fahrenheit for 7 of 7 residents (R64, R4, R7, R38, R27, R29, R29) reviewed who indicated their rooms were cold. In addition, the facility failed to provide a homelike dining experience by serving meals on hard plastic trays for 1 of 1 resident (R29) reviewed for dining, which had the potential to affect all residents who ate in the dining room.Findings include: Temperature R64's quarterly Minimum Data Set (MDS) dated [DATE], indicated a diagnosis of type 2 diabetes with circulatory complications with intact cognition. A progress note dated 11/28/25, indicated R64 reported their room was cold and wore a flannel shirt over another shirt and long pants. Maintenance director (MD)-H performed a laser temperature which revealed it was 70.5 degrees Fahrenheit (F). On 12/29/25 at 12:22 p.m., R64 was interviewed and stated it had been cold in their room, additionally, family brought in sweats and sweatshirts. Surveyor obtained temperature in the room on 12/29/25 it was 69.5 degrees F, however, the temperature by the window was 63.5 degrees F. R4's annual MDS on 6/3/25 indicated diagnosis of spinal stenosis and no cognitive impairment. On 12/29/25 at 12:53 p.m., R4 was interviewed and stated their room ranged from slightly cool, to cold every day. R4 was observed wearing at least two blankets, one up to his chin and over his arms. The temperature by head of bed was 66.6 degrees F. R7's admission MDS on 6/10/25 indicated diagnoses of osteomyelitis, failure to thrive and pressure ulcer of sacral region, and type 2 diabetes with intact cognition. On 12/29/25 at 1:38 p.m., R7 was interviewed and stated he was cold all the time. R7 wore a winter stocking hat and thick winter gloves on with four thick blankets up to his chin. The temperature in room by head of bed was 67.4 degrees F, however, by window temperature was 57 degrees F. R38's annual MDS on 1/14/25 indicated a diagnosis of traumatic brain injury with intact cognition. On 12/29/25 at 2:04 p.m., R38 was interviewed and stated it was cold in their room and the plastic on the windows stayed up all year. They stated they did not want to permanently move rooms, but it was cold in their room. R38 wore a winter hat, was fully dressed, wore an insulated hoodie, and had three blankets on with a fleece blanket over that. The radiator vent appeared broken and pulled apart. The temperature in room was 58 degrees F by the head of bed, however, temperature by window was 35 degrees F. R27 's admission MDS on 11/13/25 indicated a diagnosis of metabolic encephalopathy with intact cognition. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/29/25 at 2:30 p.m., R27 was interviewed and stated it was so cold here in my room and the whole building, and the help layer their clothes too. I close my bathroom door because there is absolutely no heat in there and when staff open this door (door to hallway) I can feel a breeze. It is too cold for me. R27 was wearing a long-sleeved shirt and sweatshirt, shawl and covered with blanket in recliner and had two blankets on the bed. The temperature in room by the head of bed was 64.4 degrees F, however, in bathroom it was 57 degrees F. R29's annual MDS on 7/22/25 indicated a diagnosis of chronic respiratory failure with intact cognition. On 12/29/25 at 3:30p.m., R29 was interviewed and stated it was cold in the room, especially at night. The temperature by the head of bed was 69.5 degrees F. R39's quarterly MDS on 9/30/25 indicated a diagnosis of cellulitis of left lower limb and alcoholic cirrhosis of the liver with intact cognition. On 12/29/25 at 4:59 p.m., R39 was interviewed and stated the room was cold, especially overnights, and they woke up freezing in the morning. The temperature by the head of bed was 69.1 degrees F. During an interview on 12/29/25 at 5:25 p.m., MD-H stated the rooms in the facility did not have thermometers or thermostats. A laser thermometer was used to test room temperatures. The building had two heat sources, one was on the roof that regulated sensors the hallways, the thermostat was set to 73 to 76 degrees, the second was the boiler. The rooms had vents above each door in some of the rooms and the vents were shut which decreased the heat's ability to enter room. MD-H stated the building was old, the windows only had a single pane of glass, if they were incorrectly shut, wind blew through them. During interview on 12/29/25 at 7:14 p.m., Executive Director stated some residents declined moving rooms, the facility offered plastic on the windows, however, the intervention did not increase the temperature to meet the required 71 to 81 degrees. During resident council meeting minutes on 12/11/25 residents stated they were cold, MD-H mentioned keep doors to rooms open because thermostat sensors were in the hallway. Also, keep windows closed, and cover windows with plastic. A facility's policy/procedure documentation regarding room temperatures, maintenance, and TELS reports for the last 6 months requested, but not received. Dining R29's quarterly Minimum Data Set (MDS) dated [DATE], indicated R29 had intact cognition and was independent with eating. During an observation on 12/30/25 at 12:12 p.m., 10 residents, including R29, were observed sitting in the main dining room. The room had multiple tables present with residents seated at each. The residents were observed to have hard-plastic trays with plates, cutlery, and drinks on top of them. During this time, no staff were observed asking or offering to remove the items from the tray and place them onto the table. (continued on next page)

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	245320	A. Building B. Wing	12/31/2025

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/31/25 at 7:33 a.m., R29 stated that meals were normally served on hard plastic trays when she ate in the dining room. R29 stated this practice made her feel like she was in a hospital, and she wished they wouldn't use the trays. During an interview on 12/31/25 at 7:52 a.m., dietary aide (DA)-A stated she assisted with passing trays in the dining room. DA-A stated they normally will give residents their food on trays that stay in place, to ensure residents have all the items needed for their meal. During an interview on 12/31/25 at 8:01 a.m., the dietary manager (DM) stated that it was a lot easier and quicker for her staff to utilize and leave food and drinks on trays, which has been their practice. The DM stated she had not realized that utilizing the trays in the dining room had bothered anyone, so now she would have her staff place the food and drinks on the table and remove the trays. A policy regarding staff assistance with dining was requested but not received.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and document review, the facility failed to obtain and document an informed consent, including with explanation of risk and benefits, for 1 of 5 residents (R9) reviewed for unnecessary medications.Findings include:R9's quarterly Minimum Data Set (MDS) assessment, dated 12/9/25, indicated R9 had moderately impaired cognition with delusions, no hallucination, no behaviors, wandering or rejection of care.During an interview and observation on 12/29/25 at 1:13 p.m., R9 was lying in bed and appeared to be waking up from taking a nap. R9 stated she had no concerns. R9 was pleasant but appeared confused in some of her responses to questions. R9's Order Summary Report, dated 12/31/25, included the following orders: -risperidone (an antipsychotic medication) - Give 0.5 milligrams (mg) by mouth two times a day for psychosis with a started date of 9/11/25.-Seroquel (an antipsychotic medication) give 50 mg by mouth two times a day for delirium with a start date of 12/18/25. R9's December Medication Administration Record (MAR), printed 12/31/25, included the following: -risperidone - Give 0.5 milligrams (mg) by mouth two times a day for psychosis with a started date of 9/11/25. The record indicated the medication was administered 31 times in the month of December. -Seroquel - give 50 mg by mouth three times a day for delirium with a start date of 8/22/25 and an end date of 12/18/25. The record indicated the medication was administered 23 times from 12/1/25 to 12/18/25. -Seroquel - give 50 mg by mouth two times a day for delirium with a start date of 12/18/25. The record indicated the medication was administered 15 times since 12/18/25. Review of R9's electronic medication record (EMR) lacked evidence of signed consent for either antipsychotic medication (risperidone or Seroquel) which would include risks, benefits and alternatives. During an interview on 12/31/25 at 11:25 a.m., registered nurse (RN)-B stated consents for any psychotropic medications were obtained by nurses on the floor. RN-B stated when a resident got admitted or when a resident started on a new psychotropic medication, the nurse obtained consent prior to administering the medication. RN-B stated if the resident could not give consent, then the family/guardian/power of attorney would be called to obtain consent. RN-B stated after consent for the medication was given, the medication would be started, and the form would be given to medical records to be uploaded in the electronic medical record (EMR) in the documents/attachment's sections. During an interview on 12/31/25 at 11:43 a.m., director of nursing (DON) stated the expectation would be that consents for psychotropic medications were completed by floor nurses prior to starting or increasing the medication. DON was unable to locate the consents for R9's risperidone or Seroquel and would follow up with surveyor if able to locate them. During follow up on 12/31/25 at about 3:15 p.m., DON stated they were unable to locate signed consents for R9 antipsychotic medications. During an interview on 12/31/25 at 2:00 p.m., R9's guardian (GUA)-A verified that they were the guardian for R9. GUA-A stated they did receive a call a while ago about R9 needing to start a new medication for agitation. GUA-A stated they gave consent to start a medication but was not sure the name of the medication or the risks of the medication. GUA-A stated they never signed a consent that reviewed risks and benefits of medications. A facility policy titled Use of Psychotropic Medications, updated 4/21/25, indicated that prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black b ox warnings for antipsychotic medications, in advance of such initiating or increase.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and document review, the facility failed provide appropriate side effect monitoring (i.e., orthostatic hypotension) with antipsychotic medication consumption for 1 of 5 residents (R9) reviewed for unnecessary medication use. Findings include: R9's quarterly Minimum Data Set (MDS) assessment, dated 12/9/25, indicated R9 had moderately impaired cognition with delusions, no hallucination, no behaviors, wandering or rejection of care. The MDS indicated R9 took antipsychotic medication. Furthermore, MDS indicated R9 required the use of a walker and wheelchair and supervision for chair to bed transfers. R9's diagnosis report included the following diagnoses: orthostatic hypotension (sudden drop in blood pressure when a person stands up), dementia (decline in mental ability), syncope and collapse (temporary loss of consciousness-fainting), and myocardial infarction (heart attack).During an interview and observation on 12/29/25 at 1:13 p.m., R9 was lying in bed and appeared to be waking up from taking a nap. R9 stated she had no concerns. R9 was pleasant but appeared confused in some of her responses to questions. R9's Order Summary Report, dated 12/31/25, included the following orders: -risperidone (an antipsychotic medication) - Give 0.5 milligrams (mg) by mouth two times a day for psychosis with a started date of 9/11/25.-Seroquel (an antipsychotic medication) give 50 mg by mouth two times a day for delirium with a start date of 12/18/25. R9's order summary lacked orders to obtain orthostatic blood pressures. R9's December Medication Administration Record (MAR), printed 12/31/25, included the following: -risperidone - Give 0.5 milligrams (mg) by mouth two times a day for psychosis with a started date of 9/11/25. The record indicated the medication was administered 31 times in the month of December. -Seroquel - give 50 mg by mouth three times a day for delirium with a start date of 8/22/25 and an end date of 12/18/25. The record indicated the medication was administered 23 times from 12/1/25 to 12/18/25. -Seroquel - give 50 mg by mouth two times a day for delirium with a start date of 12/18/25. The record indicated the medication was administered 15 times since 12/18/25. R9's MAR lacked any orthostatic blood pressures orders or evidence orthostatic blood pressures were obtained. R9's blood pressure summary report from July 2025 through December 2025 lacked evidence of completion of any orthostatic blood pressures. R9's progress notes, dated 12/1/25 to 12/31/25, reviewed and lacked evidence R9 refused orthostatic blood pressures. During an observation and interview on 12/31/25 at 10:14 a.m., nursing assistant (NA)-C stated R9 was able to transfer to her wheelchair. R9 transferred from her bed to her wheelchair with supervision from NA-C. During an interview on 12/31/25 at 10:40 a.m., registered nurse (RN)-C stated nurses were responsible for obtaining orthostatic blood pressures on residents. RN-C stated orthostatic blood pressures were not automatically done on a resident if they were on an antipsychotic medication as they were done if there was a doctor order to complete them or reason to do them. RN-C verified that R9 was able to stand. RN-C stated that antipsychotic medications can cause orthostatic hypotension. During an interview on 12/31/25 at 11:23 a.m., RN-B stated orthostatic blood pressures were completed if there was an order to obtain them. RN-B was unsure of orthostatic blood pressures were completed if a resident was on antipsychotic medications. During an interview on 12/31/25 at 1:38 a.m., director of nursing (DON) stated the expectation would be orthostatic blood pressures would be obtained if a resident was starting on an antipsychotic medication and monthly thereafter. DON reviewed R9's electronic medical record and verified orthostatic blood pressures had not been obtained for R9 and should have been as R9 as she currently took antipsychotic medications. A facility policy titled Use of Psychotropic Medications, updated 4/21/25, indicated The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., nail care and shaving) was completed and provided for 2 of 2 residents (R44, R43) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R44 - Shaving R44's quarterly Minimum Data Set (MDS) assessment, dated 11/18/15, identified R44 had intact cognition with no hallucinations or delusions, behaviors or rejection of care. MDS indicated R44 needed moderated assisted for personal hygiene which included shaving. During an interview on 12/29/25 at 1:46 p.m., R44 stated that he does not like to have any facial hair as it becomes very itchy. R44 stated he has told staff this previously. R44 stated the staff only shave him on showers days but his preference would be to be shaved daily with morning cares. R44 was observed to have approximately a quarter in beard and mustache. During an interview on 12/30/25 at 11:21 a.m., R44 was observed in his room and observed to continue to have unshaven facial hair. Two nursing assistants came in after surveyor entered to see why R44's call light was on, so surveyor ended the interview to they could assist him. R44's care plan, printed 12/31/25, identified R9 has an ADL self-care performance deficient related to limited mobility and musculoskeletal impairment and requires assistance with dressing/undressing and requires 1 staff assistance to use toilet. R44's care plan lacked identification of level of assistance R44 needs for personal hygiene such as shaving or showers. R44's Tub/Shower Transfer log, printed 12/31/25, indicated R44 last shower was 12/23/25 and required maximal assistance. R44's progress notes, dated 12/1/25 to 12/31/25, were reviewed. The progress notes lacked evidence that R44 was offered and refused to be shaved. During an interview on 12/30/25 at 1:55 p.m., nursing assistant (NA)-E stated they listened to what residents wanted when completing morning cares. NA-E verified they were familiar with R44 and completed morning cares with R44. NA-E stated R44 needed assist of 1 with cares and assist of 2 with transfers. NA-E stated they had not shaved R44's facial hair today, stating sometimes I am not able to get to the small stuff. I can't get to it all. NA-E verified that had facial hair that could be shaved. During an interview on 12/30/25 at 2:04 p.m., registered nurse (RN)-B stated morning cares should include washing a resident's face, underarms, peri-area, changing clothes, oral cares and shaving. RN-B stated typically, shaving is done on showers done but we can shave a resident anytime. RN-B stated any nursing staff should be asking a resident preference every step of the way when getting them ready in the morning or at night. During an interview on 12/31/25 at 10:27 a.m., R44 was observed to continue to have unshaven facial (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hair. R44 stated, it's still growing, and getting real itchy. During an interview on 12/31/25 at 10:37 a.m., NA-F stated shaving should be offered with morning cares. NA-F stated it appeared that R44 hadn't been shaved for about 5-7 days based on the length of the facial hair. NA-F verified R44 had a razor in his bathroom. During an interview on 12/31/25 at 10:47 a.m., NA-F stated morning cares should include the following: washing face, hands, underarms, peri-area, combing hair, shaving, brushing teeth, and changing clothes. NA-F stated they assisted R44 today with morning cares. NA-F stated they did not shave R44 or offer to shave R44 as it takes him a long time to brush his teeth and I have to multitask. NA-F stated they would shave R44's facial hair and stated it should have been done with morning cares. During an interview on 12/31/25 at 11:36 a.m., director of nursing (DON) stated the expectation would be a resident's facial would be done with bathing and as needed when staff notice that it is growing per resident's preference. A policy on activities of daily was requested and not received. R43 R43's admission Minimum Data Set (MDS), dated [DATE], identified R43 had intact cognition and required full assistance with personal hygiene cares. R43 had diagnoses of respiratory failure, muscle weakness, malignant neoplasm of left breast and chronic pain. R43's care plan, dated 11/14/25, identified R43 had an ADL self-care deficient with grooming, and required assistance of one by staff. R43's weekly body audits, dated 11/26/25 and 12/24/25, identified R43's fingers and toenails were not cleaned or trimmed. During observation and interview on 12/29/25 at 3:42 p.m., R43 stated her nails were long and dirty. She stated requested an unknown staff member to have them cleaned and trimmed, but it was not performed. R43's fingernails were observed, nails were approximately 1/4 inch long, with brown substance under nails. Her toenails were approximately 1/4 inch long and no sign of discolored substance under them. During observation and interview on 12/30/25 at 11:24 a.m., R43 stated that nails were not cut or cleaned by staff. However, family member (FM)-G trimmed right thumb and pointer finger. During interview on 12/30/25 at 2:54 p.m., nursing assistant (NA)-I stated R43's nails were not clean or trimmed on both hands, except for pointer finger and thumb on right hand. NA-I stated nail care was usually done on bath/shower days. During interview on 12/31/2025 2:04 p.m., director of nursing (DON)-B stated the expectation for nail care was to be completed on bath/shower days and as needed. If a resident asked to have nails cleaned and trimmed it was expected for staff to perform that function. Nail care was important for hygiene and overall skin integrity. A policy and procedure for ADLs was requested but not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to consistently implement a restorative nursing program (RNP) to prevent a possible decrease in range of motion (ROM) for 1 of 1 residents (R29) reviewed for ROM. Findings include:R29's quarterly Minimum Data Set (MDS) dated [DATE], indicated R29 had intact cognition with no rejection of care behaviors during the look-back period (LBP). The MDS indicated R29 had impaired ROM on both lower extremities. The MDS indicated R29 required maximum assistance with bed mobility and lower body dressing. R29's Therapy Referral for Maintenance Program dated 10/24/24, indicated that physical therapy recommended staff assist R29 with passive ROM to bilateral hips, knees, and ankles daily. R29's care plan dated 8/10/25, indicated R29 was to receive passive ROM to the bilateral hips, knees, and ankles daily. R29's task list dated 11/30/25 to 12/28/25, indicated that staff were to complete passive ROM on R29's bilateral hips, knees, and ankles daily. The report indicated the task had been refused five times, completed 17 times, charted as not applicable five times (with no further entry indicating it was completed or refused that day), and had no entry on 12/7/25, 12/19/25, and 12/20/25. During an interview on 12/29/25 at 3:37 p.m., R29 stated that staff were supposed to complete ROM with her daily, but never do it. During an interview on 12/31/25 at 8:46 a.m., nursing assistant (NA)-D stated she had worked with R29 in the past, and she would rarely refuse to complete ROM when she had time to complete it with R29. NA-D stated she often didn't feel like she had enough time to complete everything she had to do during her shift, so she often did not complete ROM when she worked with her as a result. During an interview on 12/31/25 at 9:18 a.m. with NA-B and NA-C, NA-B stated it was often hard to complete everything they needed to do during their shift. NA-B stated that if they had time to do ROM, they would, but it often didn't get done. NA-B stated that if they did complete ROM with R29, they would chart it as completed on her tasks list. During an interview on 12/31/25 at 9:10 a.m., the director of nursing (DON) stated that if a resident needed ROM, it would be added to tasks where staff could document if it was completed or not. The DON stated that after reviewing R29's medical record, staff should be completing ROM with her daily. The DON stated the NAs had notified her that they were having a hard time finding enough time to complete ROM, so the facility was looking to get a restorative aide to assist, but it had not yet happened. A policy regarding ROM was requested and not received.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to follow developed interventions for eating assistance to reduce the risk of aspiration or choking for 1 of 2 residents (R6) reviewed for nutrition. Findings include: R6's quarterly Minimum Data Set (MDS) dated [DATE], indicated R6 had severely impaired nutrition. The MDs indicated R6 required moderate assistance with transfers and personal hygiene and was independent with eating. R6's care plan dated 9/13/25, indicated R6 required setup help for eating and was to be encouraged to get out of bed for all meals. The care plan indicated R6 had a history of dysphagia (difficulty swallowing) and hemiplegia (one-sided paralysis or weakness) with a goal of having no choking episodes when eating or drinking through the review date. R6's order summary dated 11/5/25, indicated R6 had an order for a mechanical soft (soft, easier to chew food for those with chewing or swallowing difficulty) diet, was to be upright in a chair or bed while eating/drinking, should be given small bites/sips, and required total assistance with feeding. During an observation on 12/29/25 at 12:46 p.m., R6 was observed in his room lying in bed. The head of the bed was in an upright position, and the bedside table was in front of him with a meal tray with food and a beverage on it. No staff members were observed in the room with R6. R6 was observed to drink what appeared to be milk with no signs of choking or coughing noted. During an observation on 12/30/25 at 8:13 a.m., R6 was observed sitting at a table in the dining room with another resident present, but no staff at the table. Registered nurse (RN)-B was observed standing in front of a medication cart, looking at a laptop at one end of the dining room. R6 was observed to drink what appeared to be coffee independently. R6 was observed to take a piece of toast that had been cut in half and put about 75 percent of it in his mouth and chew it. R6 showed no signs of choking or coughing. During an interview on 12/30/25 at 8:16 a.m., RN-B stated that R6 was supposed to have someone sitting with him to help with eating to ensure he was eating safely. RN-B stated an aide was supposed to be assisting in the dining room, but he was unsure who was supposed to be helping and why they were not. During an interview on 12/30/25 at 10:25 a.m., the director of nursing (DON) stated staff should either be in R6's room with him or sitting with him in the dining room while he is eating to ensure he was safe. A policy regarding staff assistance with eating was requested but not received.

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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** Based on observation, interview, and document review, the facility failed to ensure ordered nutritional interventions were provided to promote weight gain for 1 of 2 residents (R6) reviewed for nutrition. Findings include: R6's quarterly Minimum Data Set (MDS) dated [DATE], indicated R6 had severely impaired nutrition. The MDS indicated R6 required moderate assistance with transfers and personal hygiene and was independent with eating. R6's care plan dated 9/13/25, indicated R6 had a potential for a nutritional problem related to dysphagia (difficulty swallowing) and hemiplegia (one-sided paralysis or weakness). The care plan indicated R6 would receive supplements per the provider's order. R6's order summary dated 11/5/25, indicated R6 had an order for a house nutritional supplement one time a day for nutritional support. The summary did not include an order for house nutritional supplements three times a day. R6's dietitian's note dated 12/17/25, indicated R6 had weight loss likely related to inadequate intake. The note indicated the dietician would continue to assess the resident monthly and would like the house nutritional supplement to be increased to three times a day between meals. R6's Weights and Vitals Summary dated 12/29/25, indicated that on 11/19/2025, the resident weighed 140 pounds (lbs) and on 12/17/2025, the resident weighed 137 lbs, which was a 2.14 percent weight loss. During an interview on 12/30/25 at 9:57 a.m., the dietician stated that because R6 had continued weight loss after she had started him on a house supplement, she had increased the frequency from once a day to three times a day on 12/17/25. The dietician stated she filled out a sheet with her order and sent it to the nurse manager and the director of nursing (DON) to be entered in the electronic medical record.During an interview on 12/30/25 at 9:11 a.m., registered nurse (RN)-D stated R6 got a house nutritional supplement once a day that was usually given to R6 after breakfast.During an interview and observation on 12/31/25 at 9:13 a.m., the DON was observed reviewing her emails and stated that it looked like they had received an email from the dietician to increase R6's supplement to three times a day. The DON stated it was the nurse manager's responsibility to enter this order into the electronic medical record, but this must not have been completed. The facility's Nourishment and Oral Nutritional Supplements policy dated 2021, indicated the director of food services or designee would maintain the nutritional supplement list using written orders and individual requests as a guide.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview and document review, the facility failed to ensure pharmacist recommendations were acted upon timely for 1 of 5 residents (R9) reviewed for unnecessary medication use.Findings include:R9's Pharmacist's Recommendation to Prescriber and Residents reviewed with No Recommendation, dated July 2025 to December 2025, were reviewed and identified the following:7/18/25: no recommendations8/17/25: Seroquel an antipsychotic medication needs appropriate diagnosis. This was signed by provider 8/20/25.9/23/25: recommendation was to consider a trial discontinuation of the agents to reduce poly-pharmacy as receiving risperidone 0.5mg twice a day and Seroquel three times a day. Prescriber responded on 12/18/25 to change Seroquel to twice a day and plant to d/c (discontinue) if possible.10/20/25: no recommendations12/16/25: recommending gradual dose reduction. Provider responded GDR being completed.The November 2025 Pharmacist Recommendation to Prescriber was not provided.During an interview on 12/31/25 at 11:42 a.m., director of nursing (DON) stated she believes she has the November 2025 pharmacy review for R9. DON verified R9's November 2025 had not been provided at this time and will provide it when located. No further information was given.A facility policy titled Medication Regimen Review Policy, updated 10/19/22, indicated all medication regimen review documents will be maintained in the resident medical record.

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	12/31/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure recommended pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 1 of 5 residents (R4) reviewed for immunizations. Also, the facility failed to document shared clinical decision making for 2 of 5 residents (R16, R27) identified as needing or being offered an updated pneumococcal immunization per CDC's Recommendation of Adult Immunizations Schedule for Ages 19 Years or Older, United States, 2025, Revised October 7, 2025.Findings include:During interview and record review with director of nursing (DON) on 12/30/25 at 11:12 a.m., DON reviewed electronic medical records (EMR's) and verified the following:R4's date of birth was 2/9/53, and the EMR lacked information on pneumococcal immunization status. DON stated they expected the facility to have documentation to support him being offered or having declined the vaccine.R16's date of birth was 6/22/1957, and the EMR identified R16 received an unnamed pneumococcal vaccine on 9/23/2015 at age [AGE], Pneumovax 23 given 3/4/2019 at age [AGE], and another Pneumovax 23 given 7/11/22 at age [AGE]. DON reviewed the CDC guidance which identified R16 should receive 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21, at least one 1 year after the last PPSV23 dose and stated it was not done. R27's date of birth was 12/22/1940, and the EMR identified Prevnar 13 was given on 10/23/2018 at age [AGE] and Pneumovax 23 was given on 11/19/2019 at age [AGE]. DON reviewed the CDC guidance which identified, Based on shared clinical decision-making, 1 dose of PCV20 or 1 dose of PCV21 at least 5 years after the last pneumococcal vaccine dose applied to R27 which was not done. DON stated facility was expected to follow the facility policy and CDC guidelines when assessing and discussing vaccination status upon admission and as recommended. In addition, DON verified there was no documentation or evidence that facility or providers discussed with R4, R16, and R27 any shared decision making on providing pneumococcal immunizations.During interview with medical director (MD) on 12/30/25 at 11:39 a.m., MD stated it was important for health care providers to include documentation of shared decision making and that R16's and R27's EMRs failed to identify this was done. In addition, MD stated R4's EMR lacked evidence of pneumococcal immunization was offered or administered at any time.Facility's Infection Control manual, updated 11/13/2024, identified, Upon admission, the resident will be assessed for: 2) Pneumococcal vaccination status, by history and All residents will be provided with the opportunity and encouraged to receive pneumococcal vaccinations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and document review, the facility failed to ensure staff were offered, and or provided education regarding the benefits and potential risks associated with COVID-19 vaccination for 3 of 3 staff (LPN-A, LPN-B, HSK-A) reviewed for COVID-19 vaccinations. Findings include:Review of Centers for Disease Control and Prevention (CDC) Clinical Guidance for COVID-19 Vaccination, updated 7/11/25, indicated the CDC recommended an updated COVID-19 vaccine for most adults ages 18 years and older, including people who live and work in long-term care (LTC) settings, get one dose of an updated COVID-19 vaccine. People 65 years and older who live and work in LTC settings should receive 2 doses of an updated COVID-19 vaccine, spaced 6 months apart.During an interview on 1/9/24 at 11:38 a.m., human resources director (HR)-F stated the facility did not have any documentation of COVID-19 vaccine being offered or education provided for licensed practical nurse (LPN)-A; LPN-B or housekeeper (HSK)-A.During an interview on 1/9/25 at 1:20 p.m., director of nursing (DON) stated she was unaware if employees were offered the COVID-19 vaccine. During an interview on 1/9/25 at 12:49 p.m., medical director (MD) stated her expectation would be for the facility to ensure staff were provided education on risk versus benefits and be offered the COVID-19 vaccine when available.The facility policy on COVID-19 vaccine dated 11/2024, identified when COVID-19 vaccine is available each staff member will be offered and provided education regarding the benefits, risks, and potential side effects of the COVID-19 vaccine. The policy also identified the facility maintains documentation that staff were offered and provided education regarding benefits and potential risks of COVID-19 vaccination.