

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Woodlake Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Bass Lake Road Crystal, MN 55428	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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: 245518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Woodlake Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Bass Lake Road Crystal, MN 55428	
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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure reasonable accommodation of resident needs and preferences upon admission to the facility for 2 of 3 residents (R1, R3) reviewed who reported concerns related to accommodation of needs upon admission to the facility. Findings include: R3's admission Record indicated admitted to the facility on [DATE] at 12:45 p.m. Diagnosis included fractures of left fibula and tibia (the two bones of the lower leg), pain in left wrist and left leg, fracture of left radius (one of two bones in your forearm), unsteadiness and dependence on other enabling machines and devices. R3's Interagency Transfer Orders dated 9/4/25, included oxyCodone 5 milligrams (mg). Give 5-10 mg every four hours as needed for pain. The orders indicated R3 had restricted weight bearing and indicated non-weight bearing on left leg and left arm, okayed for a platform walker at the left elbow. R3's Medication Administration Record (MAR) dated 9/1/25 through 9/30/25, indicated the following order: oxyCODONE HCl (hydrochloride) Oral Tablet 5 MG. Give two tablets by mouth every four hours as needed for pain rated 6-10 out of 10. The MAR indicated R3 received her first dose of oxyCodone at 7:45 p.m. on 9/7/25, for pain rated 10 out of 10, seven hours after she admitted to the facility. R3's admission assessment dated [DATE], indicated she admitted from the hospital via medical transport. The assessment indicated R3's lower left extremity was in a cast, ACE wrap. Left lower arm in cast, ACE wrap. Foley catheter in use. The assessment indicated R3 was chairfast with ability to walk severely limited or non-existent. Could not bear own weight and/or must be assisted into chair or wheelchair. Able to make frequent though slight changes in body or extremity position independently. The assessment identified frequent severe pain in the last five days that interfered with day-to-day activities. R3's care plan dated 9/7/25, identified the use of an indwelling catheter and indicated pain. The care plan directed staff to monitor for non-verbal pain indicators or change in behavior related to pain such as grimacing, change in ability to perform activities of daily living (ADL)'s and directed staff to offer nonpharmacologic interventions such as heat/cold, massage and distraction. The care plan further identified and ADL and mobility deficit and indicated she transferred using a platform walker. R3's Progress Notes indicated the following: -9/7/25 at 3:38 p.m., R3 arrived on the unit at 12:45 p.m. R3 was alert and oriented and able to make needs known. R3 was oriented to room, call lights and questions were answered as best as writer could. -9/8/25 at 5:55 a.m., R3 reported severe pain in left arm and leg, as needed oxyCodone was given around the clock to manage pain. R3 had approximately three hours of sleep the previous night. -9/9/25, Social services met with R3 and family member (FM)-B and discussed options for transitional care unit transfer as well as going to the hospital. R3 decided to go to the hospital. 9/9/25, R3 left the facility via ambulance. FM-B spoke with writer and nurse manager, verbalized wanting to go to the emergency department and not come back to the facility. During interview on 9/11/25 at 3:12 p.m., family member (FM)-B stated R3 went through 48 hours of hell, when R3 admitted to the facility on Sunday at noon and had not received pain medication prior to discharge from the hospital, got to her new room at the facility where she was transferred into bed by the Medivan driver, himself and a staff person. FM-B said there were no mobility devices in the room and staff said someone from physical therapy would be performing an assessment on Monday but until then, R3 would have to remain in bed. FM-B said a commode was brought into her room but there was no way to get R3 onto it because there were no devices. FM-B added he stayed for several hours and left for a couple hours and R3 called and asked him to come back. He stated they learned she was not going to get any pain medication because the pharmacy only delivered once a day on the weekends. He said R3 was at max pain, had not received pain medication since the morning and finally received pain medication again at 8:00 p.m. and said all they had offered prior was Tylenol. FM-B said R3 had been beside herself in pain. FM-B said the next morning he talked to social services and reported what had happened. He said a therapy assessment was not completed until 4:00 p.m. on Monday and therapy had at least brought a recliner, walker and a grab bar. FM-B said the second night was no better than the first and said R3 asked for a suppository and was assisted onto the commode and because the suppository was not effective a staff member forcibly put an adult diaper on R3 and put her back to bed. Then, around 10:00 p.m., two staff came into the room and turned on the light talking about how they were looking for something which woke R3 up. FM-B added, We had to get her out of there. FM-A said they told the social worker they were going to leave and were not coming back. During interview on 9/12/55 at 8:13 a. m. licensed practical nurse (LPN)-A stated therapy worked on the weekends sometimes but said most of the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Woodlake Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Bass Lake Road Crystal, MN 55428	
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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to maintain an environment that was clean and free from odors for 3 of 3 residents (R1, R2, R3) reviewed for environmental concerns. Findings include: During observation of the two-east unit on 9/11/25 at 10:50 a.m., a musty odor was observed outside room [ROOM NUMBER]. During observation on the east unit on 9/12/25 at 8:23 a.m., the hallway outside of room [ROOM NUMBER] smelled of urine. No trash or linen carts were in the vicinity. R1's admission Record indicated he admitted to the facility on [DATE]. Diagnosis included Surgery of digestive system, chronic pain, and weakness. During interview on 9/11/25 at 10:39 a.m., family member (FM)-A stated it smelled like death in his dad bathroom when he was at the facility even after they had cleaned it. R2's admission Record indicated she admitted to the facility 9/3/25 and resided on the two- east unit of the facility. Diagnosis included muscle weakness, DMII, hypertension and history of falls. R2's Brief interview for mental status (BIMS) dated 9/4/25, indicated her short and long terms memory was intact. During interview on 9/11/25 at 11:47 a.m., R2 stated she had been at the facility for about two weeks. R2 stated the facility has had the same carpet for 10 years and said, they dumped me in this shit hole. R2 said the carpet is stained and musty and said the housekeepers did not vacuum, just swept the carpet. R2 pulled out a bottle labeled fungicide she had ordered and said the carpet smelled better since she started using it and said she planned to spray the recliner they brought up from the basement because it stunk. R3's admission Record indicated she resided on the two- east unit of the facility. Diagnosis included fractures of left fibula and tibia (the two bones of the lower leg), pain in left wrist and left leg, fracture of left radius (one of two bones in your forearm), unsteadiness and dependence on other enabling machines and devices. During interview on 9/11/25 at 3:12 p.m., family member (FM)-B stated when R3 got to the facility, the first thing he smelled when they got to her unit was urine. FM-B said R3 had a catheter and the first night a staff member came to empty it and did not place the cap on it and the catheter was leaking urine all over the floor. FM-B said the second time the staff member emptied the catheter bag, she spilled urine on the floor then rubbed the urine into the carpet with a brown paper towel. A facility grievance form dated 8/4/25, filed by FM-C, indicated Residents room is a mess, not enough garbage cans, floor dirty. During interview on 9/12/25 at 10:01 a.m., social service designee (SSD)-A said she was aware of the concerns reported by R3. SSD- A said the concerns included the urine on the carpet, no recliner in the room and some other things. SSD-A said because of the scenarios, R3 did not think the facility was welcoming or clean. During interview on 9/12/25 at 10:52 a.m. the environmental services director (ESD) said typically if she was made aware of a concern and spoke with the resident and/or family and said if training was needed, they would do that. The ESD stated the facility currently did not have a floor technician and said she would like to have the hallways cleaned at least once per week but said they were currently stretched thin.</p>		