STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlake Healthcare and Rehabilitation Center	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify the Ombudsman of transfers and discharge for 1 of 4 residents (R17) reviewed for hospitalizations. Findings include:R17's admission Minimum Data Set (MDS) dated [DATE], indicated R17 was cognitively intact. R17 MDS indicated diagnosis of cancer, heart failure, renal insufficiency, and diabetes mellitus. R17's medical record identified the following MDS assessments:1) 7/8/25 discharge with return anticipated, with 7/17/25 entry record2) 8/1/25 discharge with return anticipated, with 8/4/25 entry record3) 8/17/25 discharge with return anticipated, with 8/25/25 entry record4) 9/29/25 discharge with return anticipated, with 10/5/25 entry record5) 10/23/25 discharge with return anticipated, with 10/29/25 entry recordA review of the facility information sent to the Ombudsman dated July 2025 through November 2025, lacked evidence of R17's name being included on the list of hospitalized residents. An interview on 12/18/25 at 11:24 a.m., director of social service (DSS) stated when residents were discharged to the hospital, a bed hold was offered and notice of voluntary discharge. DSS indicated he pulled a report monthly and sent it to the Ombudsman. DSS did not recall if R17 was on any of the reports.An interview on 12/18/25 at 1:23 p.m., the administrator stated the Director of Social Services ran a report from point click care monthly for the entire facility. The administrator stated the report was then emailed to the Ombudsman.The facility policy Ombudsman Notification of Transfer and discharge date d 11/24, revealed the facility would provide the Long-Term Care (LTC) Ombudsman's office with timely notice of discharges and transfers. The Director of Social Services/designee will provide the LTC ombudsman's office with a report of all facility-initiated transfers and discharges.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure timely follow up for recommendations from in-house provider for 1 of 1 (R161) resident reviewed for eye drops.Findings include: R161's quarterly minimum data set (MDS) dated [DATE], included R161 was cognitively intact. R161 had diagnoses of arthritis, anxiety and depression. During interview on 12/15/25 at 4:53 p.m., R161 stated she had an eye doctor appointment about a week ago had not received the eye drops that had been ordered. R161's HealthDrive Eye Care Group after visit summary (AVS) dated 12/2/25, included R161 reported itchy eyes. Under the AVS section plan, the following was listed:- Discontinue Medication Order(s) effective 12/02/2025: Artificial tears ophthalmic Solution (eye drops to treat dry eyes)- New Medication Order: olopatadine (eye drop for dry, itchy eyes) 0.2%, apply 1 drop, Both eyes, every morning for 90 days R161's order summary sheet dated 12/18/25, included artificial Tears Ophthalmic Solution 1.4 % (Polyvinyl Alcohol) Instill 1 drop in both eyes as needed for Dry eyes. Order summary failed to include olopatadine eye drops. During interview on 12/16/25 at 2:18 p.m., health unit coordinator (HUC)-A stated R161 signed a consent to see the in-house eye doctor on 11/6/25. HUC-A was not able to find any documentation in R161's medical record about an eye doctor visit. Later on 12/16/25, HUC-A was able to locate the eye doctor provider note and had it uploaded to R161's chart. During interview on 12/17/25 at 9:11 a.m., health information management manager (HIM)-B stated the process for in house eye doctor appointments was for the provider to give a summary with all the residents seen with any recommendations or changes made. The summary would be sent to the care coordinators to then follow up with the resident's primary care provider (PCP) to write an order to be sent to pharmacy. The after-visit summary was also sent to the care coordinators but could take a little longer before that was sent out and uploaded. During interview on 12/17/25 at 11:39 a.m., licensed practical nurse care coordinator (LPNCC) -A confirmed she typically received a summary with the residents who were seen by an inhouse provider along with any follow up appointments and order recommendations. LPNCC-A stated she would then follow up with the resident's PCP to get an order for any medications recommended because the in-house eye doctor did not write orders. During interview on 12/18/25 at 11:39 a.m., director of nursing (DON) stated she was new to the facility but had reviewed the eye drop concern with R161. DON stated the summary was not an order because it was not signed by the eye doctor. The process was for the HUC to provide the care coordinators with a summary and they would follow up with the PCP. The DON was unsure when the after-visit summary for R161 was received. The DON stated it would be her expectation that going forward the eye doctor would send any medication orders directly to the pharmacy because it was within their scope to write an order. During interview on 12/18/25 at 11:52 a.m., with in-house eye doctor, HealthDrive, [NAME] President (VP)-F confirmed their provider visits the facility. VP-F stated their providers were recommending providers because they see residents infrequently. They place their recommendations on the summary provided and after visit summary and it was up to the facility to follow up with the PCP to obtain an order. VP-F stated the summary gets emailed to 5 facility employees and after visit summary gets emailed to 5 facility employees the day following the eye doctor closing the visit.Facility policy for medication orders dated August 2022, failed to address timeliness or processing of inhouse provider orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, and interview the facility failed to ensure all medications and biologicals were locked in compartments which only allowed authorized personnel to have access. This had the potential to affect all residents, staff, and visitors.Findings include:During constant observation on 12/16/25 from 1:27 p.m. through 1:40 p.m., an insulin pen was observed laying on top of a locked treatment cart. The treatment cart was passed by a resident and multiple staff; none noted the insulin pen or interacted with it.On 12/16/25 at 1:40 p.m., the licensed practical nurse (LPN)-B was stopped at the cart and stated they had no idea where the pen was from or how it got there. LPN-B stated they were expected to keep the insulin pens in the medications cart, went to their cart, and pulled out a currently opened pen for the same resident. LPN-B then stated they would report the incident to their nursing supervisor and remove the pen from circulation.On 12/16/25 at 1:55 p.m., the registered nurse manager (RN)-A stated they had recently changed their processes, and the staff nurses were expected to keep the open insulin pens in the medication carts, and the unopened in the locked medication refrigerator on the unit. RN-A stated they will remove the above insulin pen from circulation as they were unsure of how long it had been out of the refrigerator or medication cart. RN-A stated the importance of storing medications correctly and safely to prevent other residents from having access to medications they were not prescribed to as it could harm them if they took it and did not need it.On 12/18/25 at 10:32 a.m., the regional director of nursing (O)-G stated they expected open insulin pens to be stored in the medication carts, and unopened pens in the locked medication refrigerator on the unit.The Medication Storage Policy dated May 2025, indicated all medications will be stored in locked compartments under proper temperature control, only authorized personnel will have access to the keys to the locked compartments, and during medication pass, the medication must be under the observation of a licensed nurse or trained medication aide or locked in the medication storage area/cart.