Electronically Submitted
March 24, 2021

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

RE: CCN: 245235
Cycle Start Date: March 2, 2021

Dear Administrator:

On March 2, 2021, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 25, 2021, the situation of immediate jeopardy to potential health and safety cited at F600 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 2, 2021, (42 CFR 488.417 (b)).

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 2, 2021, (42 CFR 488.417 (b). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 2, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Woodbury Health Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 2, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to

determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 2, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 24, 2021

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

Re: Event ID: QKIN11

Dear Administrator:

The above facility survey was completed on March 2, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00803	A. BUILDING: _____ B. WING _____	C 03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, MN 55125**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/1/21 and 3/2/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found IN compliance for state licensure. The following complaint was found to be SUBSTANTIATED: H5235108C (MN70321/	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/04/21

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2 000	Continued From page 1 MN70323/ MN70309). No state licensing orders were issued. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	2 000		

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	245235	A. BUILDING _____ B. WING _____	C 03/02/2021

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F 000	INITIAL COMMENTS On 3/1/21 and 3/2/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5235108C (MN70321/ MN70323/ MN70309) at F600, for past non-compliance. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents. The above findings constituted substandard quality of care, and an extended survey was conducted on 3/2/21. Additionally F609 was cited at current non compliance and a plan of correction is required. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600	Free from Abuse and Neglect	F 600		3/29/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/04/2021

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.

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F 600 SS=J	Continued From page 1 CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (R1) reviewed for abuse. This deficient practice resulted in an immediate jeopardy (IJ) when R2 was found in R1's room touching her bare breasts and rubbing her thighs and the facility failed to provide immediate interventions to protect other residents. The facility immediately implemented appropriate interventions and corrected the deficient practice on 2/23/21 and is being issued as past noncompliance at Immediate Jeopardy (IJ). The IJ that began on 2/23/21, was corrected on 2/25/21, when the facility implemented interventions to prevent reoccurrence. The administrator and director of nursing (DON) were notified of the IJ past noncompliance on 3/1/21, at 6:00 p.m. as a result of the immediate corrective	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

action taken by the facility.

Findings include:

R1's annual Minimum Data Set (MDS) dated 1/20/21, identified R1 as severely cognitively impaired. R1's diagnoses included dementia, bipolar disease, psychotic disorder, and depression.

R1's care plan revised 5/16/20, indicated R1 was considered a vulnerable adult and instructed staff to report any incidents of abuse immediately and ensure a safe environment before leaving alone. R1's care plan further indicated R1 had cognitive loss or alteration in thought processes affecting her judgement and decision-making process.

R2's admission MDS dated 2/14/21, identified R2 as moderately cognitively impaired. R2's diagnoses included Alzheimer's disease, dementia and traumatic brain injury.

R2's care plan revised on 2/19/21, indicated R2 had cognitive loss or alteration in thought processes affecting his judgement, decision making and thought processes. R2 will occasionally make sexually inappropriate comments as a result of his cognitive impairments. R2's care plan instructed staff to cue and supervise as needed. R2's care plan further indicated R2 was a wander risk.

R1's progress note dated 2/23/21, at 9:02 a.m. indicated, "This resident was sleeping and staff came to call writer to observe a male resident sitting beside her and trying to put hands on the upper part of her body. Resident was deeply sleeping and do not recollect exactly what was

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F 600	Continued From page 3	F 600		

happening. Staff provided 1:1 supervision for the two affected residents to make sure that they are safe for the rest of the night and that episode will not repeat again. Will continue to monitor resident status due to this incidence."

When interviewed on 3/1/21, at 9:55 a.m. R1 stated she remembered a man was in her room and lying next to her in her bed. R1 stated he touched her breasts but could not remember if he touched her bottom area. R1 stated, "He was really having fun with my uppers. What on earth protects you from something like that." R1 further stated the man was "on top of me so fast I had no opportunity to stop him. It was happening so fast. It was rather traumatic because I did not expect it." R1 further stated she made it clear she did not want to have any relations. R1 did not know his name and stated she had not seen him in this facility prior to that night. R1 further stated no staff came in to interrupt this event.

When interviewed on 3/1/21, at 10:27 a.m. social worker (SW)-A stated she was informed of the incident by licensed practical nurse (LPN)-A when she arrived at the facility on the morning of 2/23/21. SW-A stated upon admission, R2 was known to be a wandering risk but was not aware of any previous sexually inappropriate behavior. SW-A stated they were aware R2 had wandered while on the transitional care unit (TCU) prior to his transfer to the long-term care (LTC) unit.

When interviewed on 3/1/21, at 12:01 p.m. nursing assistant (NA)-A stated during the night shift on 2/23/21, around 2:10 a.m. she noticed R2 was not in his bed, so she immediately went across the hall and found R1 in R2's room. NA-A stated, "I saw [R2] in the room sitting on the edge

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F 600	Continued From page 4	F 600		

of the bed, feet on floor and his body facing privacy curtain." NA-A further stated she saw R2's hands on R1's body. NA-A stated R2 did not notice her so she backed out of the room and went to get a coworker. NA-A stated she left the room because she went to get a witness. NA-A stated she got NA-B and licensed practical nurse (LPN)-A to returned to R1's room with her. They turned on the light and saw R2 sitting on R1's bed with his hands on R1. NA-A stated R1's night gown had buttons down the front which were all unbuttoned with her breasts exposed. NA-A stated R2 was directed back to his room, but he came out again at which time registered nurse (RN)-A then escorted him back to his room. NA-A stated RN-A instructed them to provide 1:1 supervision. NA-A stated 1:1 supervision means that someone would sit with the resident in their room all the time. NA-A further stated that 1:1 supervision was not possible that night due to staffing. NA-A stated she watched R2's room instead from the hallway so she could watch for other residents that tend to wander at night as well. NA-A stated R2 fell asleep and did not come out of his room until later in the shift during rounds when she heard voices in the hall and saw R2 in the hallway walking back into his room.

When interviewed on 3/1/21, at 12:35 p.m. LPN-A stated the nursing assistants asked him to go to R1's room on 2/23/21 around 2:12 a.m. When he arrived at her room, he saw R2 sitting on the edge of R1's bed and had R1's leg up over R2's leg. LPN-A stated R2 had his hands on R1's breast area and that "there was a lot of touching." LPN-A further stated, "We just got [R2] off and explained to him that it was not appropriate." LPN-A stated that there was touching of R1's bottom part but her brief had not been removed.

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F 600	Continued From page 5	F 600		

LPN-A stated he reported the incident to RN-A. LPN-A stated RN-A instructed them to put R2 back to bed and place on 1:1 supervision. LPN-A stated he instructed nursing assistant (NA)-A to monitor R1 and R2 very closely, since their two rooms faced each other, NA-A could watch to make sure nothing like that would happen again. LPN-A stated he thought R2 stayed in his room the rest of that night as he did not receive any reports from NA-A of R2 leaving his room. LPN-A stated he told social worker (SW)-A about the incident as soon as he saw her in the morning. LPN-A stated SW-A then notified the director of nursing (DON) about the incident.

When interviewed on 3/1/21, at 2:16 p.m. RN-A stated she was notified by LPN-A on 2/23/21 around 2:20 a.m. that staff had to pull R2 out of a female resident's room (R1). RN-A stated LPN-A did not provide details about the incident. RN-A stated she assisted R2 back to his room and then told staff to provide 1:1 supervision. RN-A stated 1:1 supervision meant that someone should be close to the room to see if he came out and if so redirect back to his room. RN-A further stated when she talked to LPN-A later, he reported that R2 was sleeping. RN-A further stated that she did not report the incident to the DON because she was not aware of any sexual inappropriateness that night. RN-A stated she was familiar with R2 when he was on the TCU and that R2 would come out of his room naked almost every night. RN-A stated one night R2 grabbed her breasts.

When interviewed on 3/1/21, at 2:51 p.m. RN-B stated she heard about the incident on the morning of 2/23/21. RN-B stated staff provided 1:1 supervision for R2 from that morning until he

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	245235	A. BUILDING _____ B. WING _____	C 03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, MN 55125**

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F 600	Continued From page 6	F 600		

was discharged on 2/25/21. RN-B stated that 1:1 supervision meant that there was a dedicated staff member with the resident at all times. RN-B further stated that 1:1 supervision would not have been possible on the shift that the incident occurred since there was not any extra staff member available. RN-B stated staff reported to her that morning that they were keeping a close eye on R2 during that night and that he had no further incidents of wandering.

When interviewed on 3/1/21, at 10:46 a.m. NA-C stated 1:1 supervision meant someone would stay with the resident all the time and watched them very closely. "Stay with them right by their side."

When interviewed on 3/1/21, at 10:52 a.m. LPN-B stated 1:1 supervision meant that you have staff with the resident at all times.

When interviewed on 3/1/21, at 1:48 p.m. family member (FM)-B stated R2 had an incident of groping a female resident while residing in a different facility. FM-B stated told this facility about his prior hypersexuality behaviors but could not recall using the term groping. FM-B further stated she had been told of an incident on the TCU when R2 had inappropriate language and behaviors to a female staff member. "We really need to have him under close supervision."

When interviewed on 3/1/21, at 9:07 a.m. DON stated two staff were currently on suspension because the camera footage from the night of the incident indicated staff did not provide 1:1 supervision for R2 and did not notify her about the incident that night as was her expectation. DON stated R2 was eventually placed on 1:1

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supervision which continued until he was discharged on 2/25/21.

When interviewed on 3/1/21, at 3:03 p.m. DON stated having no knowledge of prior sexual behavior or wandering upon admit. DON stated R2 started wandering while on the TCU but was not intrusive. DON further stated that the TCU staff could easily redirect R2 when he wandered. DON stated R2 was transferred to LTC after TCU because of his wandering and there would be "more eyes on him being on LTC. There are more staff out and rounding and others [residents] wandering at night." DON stated LPN-A continually changed his story about the incident when interviewed. DON stated LPN-A told NA-A to be attached by the hip to R2 and then LPN-A kept coming out of the office to check that this was being done. DON stated according to the video surveillance, NA-A did not provide 1:1 supervision to R2 and LPN-A did not come out of the nurse's office to check on the 1:1 supervision DON further stated that per the video surveillance no staff intervened when R2 came out of his room and entered those other two rooms. DON stated there were two NAs and one nurse on that unit that night and that there were several options for safely providing 1:1 supervision to R2 for the remainder of that shift.

R1's progress note dated 2/23/21, at 9:10 a.m. indicated, "Per nursing report, staff walked into resident's room and found resident [R2] touching her breasts and genital area."

Previous progress note revealed:
-R2's progress note dated, 2/16/21, at 2:41 p.m. indicated, "Writer placed phone call to FM-B to inform her of events occurring on NOC

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[night] shift as well as few comments that were sexually inappropriate that were directed at staff."

-R2's progress note dated 2/19/21, at 11:47 p.m. indicated, "MOOD AND BEHAVIOR: Patient wandering throughout the unit. Sexually inappropriate with female staff including inappropriate touching."

-R2's progress note dated 2/22/21, at 11:15 a.m. indicated, "Pt transferred up to [LTC] @1100."

R2's progress note dated 2/23/21, at 3:01 a.m. indicated, "A behavior note was completed for [R2] due to the following behavior: Nar [nursing assistant registered] reported to this writer about the verbal sexual behavior from the part of this resident asking her to come and lay by his side on top of his bed. 2 [second] Nar called this writer to [R1's room] to see this resident committing physical sexual action on female resident [R1] by the window. Resident was observed touching the breast and the private part of the female resident."

Review of the facility incident investigation report indicated camera footage timeline for 2/23/21:

1:58 a.m. Resident [R2] observed on the [LTC] hallway shirtless with shoes/socks on and a gown wrapped around his waste [sic]. Resident just walking the hallway.

1:59:57 a.m. [NA-A] approached [R2] and returns him to his room.

2:03 a.m. [R2] leaves his room and enters [R1's room].

2:10:31 a.m. [NA-A] looks into [R2's] room and then turns around and sees [R2] in [R1's room] and enters [R1's room].

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F 600	Continued From page 9 2:10:45 a.m. [NA-A] leaves [R2's room] and runs down the hallway. 2:11:19 a.m. [NA-A] returns with [NA-B]-one enters the room while the other stands in doorway. NA in doorway then enters [R1's room] as well. 2:11:47 a.m. [NA-A and NA-B] leave the room and walk back towards the nurse station. 2:12:36 a.m. [NA-A and NA-B] return with [LPN-A]. 2:17:22 a.m. Staff return [R2] to his room. 2:32:20 a.m. [R2] leaves his room and enters [R4's room] 2:33:13 a.m. [R2] exits [R4's room]. 4:41:14 a.m. [R2] leaves his room and enters [R1's room]. 4:45:00 a.m. [R2] exits [R1's room], walks in the hallway briefly and returns to his room. Review of facility policy Vulnerable Adult/Maltreatment - Communication, Prevention, and Reporting, last revised 8/19, indicated, "It is the facility's responsibility to ensure the resident is free from abuse, neglect mistreatment, misappropriation of resident property and exploitation." The policy further indicated, "Sexual abuse is non-consensual sexual contact of any type with a resident." The past noncompliance immediate jeopardy began on 2/23/21, was corrected on 2/25/21. When the DON and administrative staff was made aware of the incident on 2/23/21, the facility placed R2 on 1:1 supervision until he was discharged on 2/25/21. Review of the training sheets dated 2/23/21, 2/24/21 and 2/25/21, identified all staff were trained in regards to the Vulnerable Adult Abuse and Reporting policy. The facility initiated a process for nurse managers and	F 600		

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F 600	Continued From page 10 DON to review the 24 hour communication report daily and ensure appropriate interventions were immediately implemented including reporting appropriately. An audit process was established through risk management to ensure this review process was completed timely. On 3/1/21 and 3/2/21, this audit process was reviewed and confirmed through interviews with the DON and nurse manager. During interviews on 3/1/21, from 10:45 a.m. to 3:00 p.m. and again on 3/2/21, from 10:30 a.m. to 12:00 p.m. licensed and unlicensed staff verbalized understanding of training on the Vulnerable Adult Abuse and Reporting policy. Staff interviews confirmed the facility implemented corrective action prior to the survey and therefore this will be cited at past noncompliance.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		4/12/21

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F 609	Continued From page 11 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of sexual abuse to the state agency (SA) within two hours for 2 of 3 residents (R1 and R2) reviewed for abuse. Findings include: R1's annual Minimum Data Set (MDS) dated 1/20/21, identified R1 as severely cognitively impaired. R1's diagnoses included dementia, bipolar disease, psychotic disorder, and depression. R1's care plan revised 5/16/20, indicated R1 was considered a vulnerable adult and instructed staff to report any incidents of abuse immediately and ensure a safe environment before leaving alone. R1's care plan further indicated R1 had cognitive loss or alteration in thought processes affecting her judgement and decision-making process. R2's admission MDS dated 2/14/21, identified R2 as moderately cognitively impaired. R2's diagnoses included Alzheimer's disease, dementia and traumatic brain injury.	F 609	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. Incident was immediately reported once facility management was informed. Resident was interviewed and family updated. Resident was sent to ER for evaluation. Nurses and NAR's involved were suspended pending investigation and disciplinary action was taken. 2. All residents residing on unit were interviewed as able to ensure they felt safe and no further incidents occurred. Camera footage was also reviewed. No other concerns were noted.	

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F 609	Continued From page 12 R2's care plan revised on 2/19/21, indicated R2 had cognitive loss or alteration in thought processes affecting his judgement, decision making and thought processes. R2 will "occasionally make sexually inappropriate comments as a result of his cognitive impairments." R2's care plan instructed staff to "cue and supervise as needed." R2's care plan further indicated R2 was a wander risk. When interviewed on 3/1/21, at 9:55 a.m. R1 stated she remembered a man was in her room and lying next to her in her bed. R1 stated he touched her breasts but could not remember if he touched her bottom area. R1 stated, "He was really having fun with my uppers. What on earth protects you from something like that." R1 further stated the man was "on top of me so fast I had no opportunity to stop him. It was happening so fast. It was rather traumatic because I did not expect it." R1 further stated she made it clear she did not want to have any relations. R1 did not know his name and stated she had not seen him in this facility prior to that night. R1 further stated no staff came in to interrupt this event. When interviewed on 3/1/21, at 12:01 p.m. nursing assistant (NA)-A stated she noticed on 2/23/21, around 2:10 a.m. R2 was not in his bed, so she immediately went across the hall and found R1 in R2's room. NA-A stated, "I saw [R2] in the room sitting on the bed, feet on floor and his body facing privacy curtain." NA-A further stated she saw R2's hands on R1's body. NA-A stated R2 did not notice her so she backed out of the room and went to get a coworker. NA-A stated she got NA-B and licensed practical nurse (LPN)-A to returned to R1's room with her. They turned on the light and saw R2 on R1's bed with	F 609	3. Vulnerable Adult Policy was reviewed. All staff will receive re-education on Immediate Reporting Requirements. Education will be completed by 4/12/2021. 4. DNS or designee will complete random weekly audits x1 month and then monthly audits x2 months to ensure staff compliance with immediate reporting of VA issues. 5. Audit results and the data collected will be presented to the QAPI committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations. Person responsible: Executive Director, Director of Nursing	

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his hands on R1. NA-A stated R1's night gown had buttons down the front which were all unbuttoned with her breasts exposed. NA-A stated registered nurse (RN)-A instructed them to provide 1:1 supervision.

When interviewed on 3/1/21, at 12:35 p.m. LPN-A stated the nursing assistants asked him to go to R1's room. When he arrived at her room, he saw R2 sitting on the bed R1's bed and had R1's leg up over R2's leg. LPN-A stated R2 had his hands on R1's breast area and that "there was a lot of touching." LPN-A further stated, "We just got [R2] off and explained to him that it was not appropriate." LPN-A stated he reported the incident to RN-A. LPN-A stated RN-A instructed them to put R2 back to bed and place on 1:1 supervision. LPN-A stated he instructed NA-A to monitor R1 and R2 very closely. LPN-A stated he told social worker (SW)-A about the incident as soon as he saw her in the morning. LPN-A stated SW-A then notified the director of nursing (DON) about the incident.

When interviewed on 3/1/21, at 10:27 a.m. SW-A stated she was informed of the incident by LPN-A when she arrived at the facility on the morning of 2/23/21.

When interviewed on 3/1/21, at 2:16 p.m. RN-A stated being notified by LPN-A that staff had to pull R2 out of a female resident's room. RN-A stated LPN-A did not provide details about the incident. RN-A stated she told staff to provide 1:1 supervision. RN-A further stated that she did not report the incident to the DON because she was not aware of any sexual inappropriateness that night. RN-A stated she was familiar with R2 when he was on the TCU and that R2 would come out

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F 609	Continued From page 14	F 609		

of his room naked almost every night. RN-A stated one night R2 grabbed her breasts.

When interviewed on 3/1/21, at 9:07 a.m. DON stated one of the nurses was on suspension due to not ensuring R2 was placed on 1:1 supervision and for not notifying the DON of the allegation of abuse. The DON further stated it was her expectation she should have been notified of the incident that night.

Review of the facility report titled, Reportable Incident Camera Timeline: 2/23/21, indicated LPN-A entered R1's room on 2/23/21, at 2:12 a.m. with NA-A and NA-B.

Review of the nursing home incident reporting (NHIR) intake form indicated the allegation of sexual abuse was reported on 2/23/21, at 8:51 a.m.

Review of facility policy Vulnerable Adult/Maltreatment - Communication, Prevention, and Reporting, last revised 8/19, indicated, "During the shift that the alleged abuse/neglect or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their Supervisor, after securing the resident's safety. Following the review of the situation, the Supervisor will immediately report to the Administrator and the Director of Nursing." The policy further indicated, "The Administrator or Director of Nursing shall determine if the incident/allegation meets the criteria for "reportable Incident." All incidents deemed reportable under MN statute are submitted to MDH via the on-line Reporting System immediately but no later than 2 hours after forming the suspicion)."

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 11, 2021

Shirley Brekken, Executive Director
Board of Nursing
Park Plaza Building
2829 University Avenue Southeast, Suite 500
Minneapolis, Minnesota 55414

Dear Ms. Brekken:

This is relative to a full survey conducted at Woodbury Health Care Center, 7012 Lake Road, Woodbury, MN, 55125 and completed on March 2, 2021.

At the time of this survey it was determined that the residents in this facility have received substandard quality of care.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The director of nursing at the time of the survey was Ellen Siebenaler.

If you have any questions on this matter, please do not hesitate to call me.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

April 11, 2021

Dr. Sarah D'Heilly
Health Partners Community Senior Care
Mailstop 26602G
PO Box 1309
Minneapolis, MN 55440

Dear Dr. D'Heilly:

The Minnesota Department of Health - Health Regulation Division is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under § 483.10 Residents Rights, § 483.12 Freedom from Abuse, Neglect, and Exploitation, § 483.24 Quality of Life § 483.25 Quality of Care, § 483.40 Behavioral Health Services, § 483.45 Pharmacy Services, § 483.70 Administration, or § 483.80 Infection control, which constitutes either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of Woodbury Health Care Center, 7012 Lake Road, Woodbury, MN, 55125, which was completed on March 2, 2021, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

F600 - Free From Abuse and Neglect

Freedom from Abuse, Neglect, and Exploitation (§ 483.12). Regulations in this area grant residents the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

The above facility has prepared a plan to correct the deficiencies which we found during the survey. You can assist by discussing the survey findings with the facility's medical director. Copies of the survey findings which provide detailed information on the violations can be reviewed at the facility.

If you have any questions, please feel free to contact me.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 11, 2021

Randy Snyder, Executive Director
Board of Nursing Home Administrators
Park Plaza Building
2829 University Avenue Southeast, Suite 440
Minneapolis, Minnesota 55414

Dear Mr. Snyder:

The Minnesota Department of Health - Health Regulation Division is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the Board of Nursing Home Administrators whenever we determine that substandard quality of care has been provided to residents. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under § 483.10 Residents Rights, § 483.12 Freedom from Abuse, Neglect, and Exploitation, § 483.24 Quality of Life, § 483.25 Quality of Care, § 483.40 Behavioral Health Services, § 483.45 Pharmacy Services, § 483.70 Administration, or § 483.80 Infection Control, which constitutes either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of Woodbury Health Care Center, 7012 Lake Road, Woodbury, MN, 55125, which was completed on March 2, 2021, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

F600 - Free From Abuse and Neglect

Freedom from Abuse, Neglect, and Exploitation (§ 483.12). Regulations in this area grant residents the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The administrator is Mr. Michael Karel.

If you have any questions, please feel free to contact me.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

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Health Regulation Division
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cc: Licensing and Certification File