MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Woodbury Villa
7008 Lake Road
Woodbury, Minnesota 55125-2499
Washington County

Report #: HL21870004

Date: May 27, 2015

Date of Visit: March 27, 2015
Time of Visit: 9:00 a.m. – 2:30 p.m.

By: Lisa Jacobsen, R.N., Special Investigator

Type of Facility: ☐ Nursing Home ☐ HHA ☒ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged,** neglect of supervision occurred when a fire in the building resulted in a death of a client and serious injury to two other clients.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)

☑ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

The preponderance of evidence established that neglect of supervision occurred when the facility failed to protect the safety of the clients that received services from the licensee, when the licensee was aware that Client #1 continued to smoke cigarettes unsafely in the building and/or his apartment for approximately one year. A fire in Client #1's apartment occurred and the client died as a result of the fire. Client #2 and Client #3 were transferred to the hospital for evaluation of smoke inhalation and were treated and released that same day.

The facility had three floors with seventy-one client receiving home care services. Client #1 resided on first floor in an apartment at the end of the wing. Nine other clients resided on that wing.

The Tenant Handbook indicated the following related to smoking in the facility: "Smoking is not allowed in any apartment or inside the building. This policy applies to all tenants, visitors and guests. This applies to regular and e-cigarettes."

Client #1 had diagnoses of alcohol dependence and chronic airway obstruction, which required the client to be on continuous oxygen. The client was alert and oriented to person, place and time. The client was identified as having behavior issues such as; resistive to assistance with activities of daily living, continued drinking alcohol in her/his apartment, smoked outside with her/his oxygen tank on with tubing and cannula on her/his lap and smoked in her/his apartment at times. Behavioral Contracts were developed, but Client #1 remained non-compliant. The client was independent with most of his personal cares and only received assistance with medication administration and safety checks throughout the day. The client drove her/his car and had access to alcohol and cigarettes at a store.

Over a period of approximately one year prior to the fire in Client #1's apartment, the following notations were noted in the client's medical record related to the client's noncompliance with smoking:
On April 16, 2014, the client was observed smoking at the end of the east hall entrance, with her/his wheelchair propping the door open, smoking. The client's oxygen tank was on the back of her/his wheelchair and the client's oxygen tubing was on her/his lap. On November 17, 2014, the client was observed lying in bed smoking a cigarette. On November 19, 2014, smoke odor was noted in the hallway. Client #1 admitted to smoking in her/his apartment the evening before. Cigarettes, a lighter and an ashtray were noted on the client's nightstand near her/his bed and cigarette butts were noted in the garbage can near the client's bed. On December 1, 2014, cigarette smoke and alcohol smell was noted in the client's apartment. On January 13, 2015, there was a report of smoke smell in the client's apartment. The client was observed in bed with the oxygen concentrator running and the tubing/nasal cannula on the floor. When questioned if the client had been smoking, the client stated,

"Two puffs, I'm not going to lie." On February 25, 2015, the client was observed sitting in her/his apartment with the oxygen tubing on her/his chest smoking. On March 3, 2015, a nurse noted some small dark brown circles on the client's bed sheet next to the pillow the size of the end of a cigarette. Partially burned cigarettes were noted on the client's bedside table. On March 13, 2015 at the client's 5:00 a.m. safety check, the client's apartment smelled of smoke. On March 16, 2015, cigarette smoke was noted in the corridor near the client's apartment. The client was in bed with the oxygen on and the client's bedroom appeared hazy and had a very strong odor of cigarette smoke. On March 23, 2015 at 2:24 a.m., the client was observed smoking and drinking in her/his apartment. On March 23, 2015 at 7:37 a.m., smoke smell was noted in the hall. When staff entered the client's apartment, a very strong cigarette smoke smell was noted and the client's apartment was very hazy. The client admitted to smoking earlier in her/his apartment. On March 25, 2015 at 11:15 p.m., smoke smell was noted in the hall. The client admitted to smoking in bed and putting the cigarette out in beer cans.

Two days after the last notation in Client #1's record, related to the client's noncompliance with smoking, the following events occurred in the early morning: Staff completed a safety check on Client #1 at 2:30 a.m. The client was in bed, appeared intoxicated and the client's oxygen was off. Client #1 refused to put the oxygen on and kicked the staff person out of the room. At 3:30 a.m., a nurse spoke with Client #1 about the importance of putting her/his oxygen on. The client put her/his oxygen on and staff left the client's room. At approximately 4:15 a.m., the nurse was alerted to a smoke-flashing screen on the computer. The nurse ran to the client's room, and noted the client's bed was in flames. 911 was called and the clients were evacuated.

Client #1's Autopsy Report and Death Certificate indicated the immediate cause of death was "Laryngeal Edema" due to "inhalation of heated air" due to an "apartment fire." The death Certificate indicated the injury occurred due to "probable cigarette use." The autopsy report indicated Client #1's blood alcohol was 0.085 gm/dl (grams per deciliter).

Client #1 and Client #2, who resided in apartments on the same wing as C1, were transferred to the hospital for medical evaluation due to smoke inhalation. Client #2, who had a history of asthma, had a chest-x-ray completed and was administered a nebulizer treatment in the emergency room. Client #3 was examined in the emergency room. Both clients were discharged from the hospital that same day.

Administrative staff spoke to Client #1 regarding his noncompliance with smoking and had the client sign documents six times in approximately one year, acknowledging that s/he had violated the lease and rules at the facility by smoking in her/his apartment. On November 19, 2014, the client was given a written notice that if s/he continued to smoke cigarettes in her/his apartment, it would leave the facility no choice but to start an eviction process. On December 31, 2014, the client was given a written notice that if s/he was found smoking in her/his apartment it was a breach of the rental agreement. In addition, the notice indicated that if it was determined that her/his tenancy was detrimental to the health, safety or welfare of the client or other clients, staff or volunteers, the client would be given a 30-day written notice to terminate its rental agreement. On January 14, 2015, the client was given a written notice titled, "Final Warning Regarding Smoking." The warning indicated if the client was found smoking in her/his apartment or on the premises, the client would have breached her/his obligation of the rental agreement and the rental agreement would be terminated. The client continued to smoke in her/his apartment, at times with oxygen on.

Client interviews revealed that they voiced concerns to staff regarding Client #1 smoking in her/his apartment. Approximately one month before the fire, another client made a formal written complaint to management regarding Client #1's smoking and was told that the situation was being worked on.

Numerous staff interviews revealed staff was concerned about the safety of Client #1 and other clients in the facility, because of Client #1's unsafe smoking practices. Staff indicated the majority of the time when the

client was non-compliant with smoking in her/his apartment, with or without oxygen on, these incidences occurred when the client had been drinking alcohol. Staff stated they reported these incidents to administrative staff and were instructed to document the occurrences in the client's record.

Administrative staff were questioned as to the measures they took to keep Client #1 and the other clients in the facility who received services from the licensee safe, with Client #1's non-compliance with smoking in her/his apartment. Administrative staff indicated a little over two weeks prior to when the fire occurred, additional safety checks of the client were started at 11:00 p.m. and 3:00 a.m. every overnight shift. In addition, administrative staff attempted to get assistance from other agencies to assist, and staff continued to look for alternate placement for Client #1. Administrative staff acknowledged Client #1 had the potential to be a safety concern to her/himself and the other clients of the facility when s/he was drinking and non-compliant with smoking.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility is responsible for the neglect of supervision. Although the facility had a policy of no smoking in the building, the facility did not enforce the policy for Client #1. Numerous staff reported to administrative staff concerns related to the client's unsafe smoking, although an adequate safety plan to keep the clients safe was not put into place.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Home Care (MN Rules Chapter 4668). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records ☐ Care Guide

☒ Medication Administration Records ☒ Treatment Sheets

☐ Facility Incident Reports

☒ ADL (Activities of Daily Living) Flow Sheets

☒ Physician Orders

☒ Nurses Notes

☐ Activities Reports

☐ Therapy and/or Ancillary Services Records

☐ Skin Assessments

☒ Physician Progress Notes

☐ Laboratory and X-ray Reports

☐ Social Service Notes

☐ Meal Intake Records

☐ Weight Records

☒ Assessments

☒ Care Plan Records

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☒ Medical Examiner Records ☒ Death Certificate

☒ Police Report

Additional facility records:

☐ Resident/Family Council Minutes

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports

☐ Call Light Audits

☒ Personnel Records/Background Check, etc.

☒ Facility In-service Records

☒ Facility Policies and Procedures

☐ Other, specify: _____

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A Specify: The client had died.

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): (•) Yes ( ) No ( ) N/A Specify: _____

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: (•) Yes ( ) No ( ) N/A Specify: _____

Did you interview the resident(s) identified in allegation: ( ) Yes (•) No ( ) N/A Specify: The client had died.

Did you interview additional residents: (•) Yes ( ) No

Total number of resident interviews: 2

Interview with staff: (•) Yes ( ) No ( ) N/A Specify: _____

Tennessen Warning given as required: (•) Yes ( ) No

Total number of staff interviews: 8

Physician interviewed: ( ) Yes (•) No

Nurse Practitioner interviewed: ( ) Yes (•) No

Interview with Alleged Perpetrator(s): ( ) Yes ( ) No (•) N/A Specify: No alleged perpetrator identified.

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ( ) Yes , date subpoena was issued _____ ( ) No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☒ Other: Specify State Ombudsman's Office and Veterans Administration Social Services

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☐ Safety Issues	☒ Facility Tour

☐ Infection Control ☐ Cleanliness ☐ Injury

☐ Use of Equipment ☐ Transfers ☐ Incontinence

☐ Call Light ☐ Other: _____

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ◉ Yes ○ No Specify: Photos of Client #1's room were taken.

xc: Health Regulation Division – Home Care and Assisted Living Program
Ramsey County Medical Examiners
Woodbury City Police Department
Washington County Attorney
Woodbury City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21870	A. BUILDING: _____ B. WING _____	C 04/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY VILLA	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
0 000	Initial comments A complaint investigation was conducted to investigate case #HL21870004. The following correction order is issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the Minnesota Department of Health, Division of Compliance Monitoring. Office of Health Facility Complaints: 85 East Seventh Place, Suite 220, P.O. Box 64970, St. Paul, Minnesota 55164-0970.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state Statutes/Rules for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute/Rule number and the corresponding text of the state Statute/Rule out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
0 030	144A.44 Subd.1(2) Up-to-date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who receives home care services has these rights: (2) the right to receive care and services	0 030		

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0 030	Continued From page 1 according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services; This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to protect the safety of the clients that received services from the licensee, (Seventy-one clients resided at the facility) when the licensee was aware that C1 continued to smoke cigarettes unsafely in the building and/or his apartment for approximately one year. The findings included: The Tenant Handbook, (undated), indicated the following related to smoking: Smoking is not allowed in any apartment or inside the building. This policy applies to all tenants, visitors and guests. This applies to regular and e-cigarettes." Observations on March 27, 2015 at 9:00 a.m. revealed Woodbury Villa was a building that had 3 floors. Seventy-one clients received services from the licensee. C1 resided on first floor in an apartment at the end of a wing. There were 9 other clients that resided on that wing. C1's record was reviewed. C1 began receiving services on April 7, 2014 and had diagnoses of alcohol dependence and chronic airway obstruction which required continuous oxygen. A registered nurse baseline assessment dated	0 030		

Minnesota Department of Health

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0 030	Continued From page 2 March 10, 2015 indicated the client was alert and oriented to person, place, and time, had behavior issues and could be verbally abusive towards staff. The assessment indicated C1 was resistive to help with his activities of daily living, continued to drink alcohol in his apartment, would smoke outside with his oxygen tank on and tubing and cannula on his lap and would smoke in his apartment at times. The assessment indicated that Behavioral Contracts were attempted but the client remained non-compliant. C1's Vulnerability Assessment dated March 10, 2015 indicated the client could follow directions, but was non-compliant at times and his noncompliance was also dependant upon his level of intoxication. The assessment also indicated the client was susceptible to abuse from others, because the client would attempt to smoke in his apartment and his neighbors were aware of this and often complained to management. Staff were to intervene as necessary if problems arose. C1's progress notes indicated the following regarding the client's non-compliance with smoking: April 16, 2014 . C1 was observed smoking at the end of east hall entrance, wheelchair propping open door smoking. C1's oxygen tank was on the back of his wheelchair and the client's oxygen tubing was on his lap. November 17, 2014: C1 was laying in bed smoking a cigarette. November 19, 2014: Smoke odor was noted in the hallway. C1 admitted to smoking in his apartment the evening before. Cigarettes, lighter and ash tray were noted on C1's nightstand near his bed and cigarette butts were noted in garbage	0 030		

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0 030	Continued From page 3 can near the client's bed. December 1, 2014: Cigarette smoke and alcohol smell was noted in C1's apartment. January 13, 2015: There was a report of smoke smell in C1's apartment. C1 was in bed with his oxygen concentrator running with the tubing/nasal cannula on the floor. When questioned if C1 had been smoking, C1 stated, "2 puffs, I'm not going to lie." February 25, 2015: C1 was observed sitting in his apartment with his oxygen tubing on his chest smoking. March 3, 2015: The nurse noted some small dark brown circles on C1's bed sheet next to his pillow the size of the end of a cigarette. There were partially burned cigarettes on the client's bedside table. March 13, 2015: At C1's 5:00 a.m. safety check, the client's apartment smelled smokey. March 16, 2015: Cigarette smoke was noted in the corridor near C1's apartment. The client was in bed with oxygen on and the client's bedroom looked hazy and had very strong odor of cigarette smoke. March 23, 2015 at 2:24 a.m.: C1 was smoking and drinking in his apartment. March 23, 2015 at 7:37 a.m.: Smoke smell was noted out in the hall and when staff entered C1's apartment a very strong cigarette smoke smell was noted and the client's apartment was very hazy. C1 admitted to smoking earlier in his apartment. March 25, 2015, At 11:15 p.m.: Smoke smell was noted in the hall. C1 admitted to smoking in bed and putting the cigarette out in beer cans. A letter submitted to the investigator dated April 6, 2015 by the assistant housing director indicated the following events occurred the morning of March 27, 2015: Staff completed a safety check	0 030		

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0 030	Continued From page 4 on C1 at 2:30 a.m. C1 was in bed, appeared intoxicated and C1's oxygen was off. C1 refused to put the oxygen on and kicked the staff person out of the room. At 3:30 a.m., a nurse spoke with C1 about the importance of putting his oxygen on. C1 put his oxygen on and staff left the client's room. At approximately 4:15 a.m., C1 was alerted to a smoke flashing screen on the computer. C1 ran to C1's room, and noted C1's bed was in flames. 911 was called and the clients were evacuated. C1's Death Certificate indicated the immediate cause of death was "Laryngeal Edema" due to "inhalation of heated air' due to an "apartment fire." The death Certificate indicated the injury occurred due to "probable cigarette use." C2 and C3, who resided in apartments on the same wing as C1, were transferred to the hospital on March 27, 2015 for medical evaluation due to smoke inhalation. C2 and C3s' hospital records were reviewed. C2 who had a history of asthma had a chest-x-ray completed and was administered a nebulizer treatment in the emergency room. C3 was examined in the emergency room. Both clients were discharged from the hospital that same day. Although documents signed by C1 indicated the client acknowledged that he had violated his lease and rules at the facility by smoking in his apartment dated April 17, 2014, November 19, 2014, December 31, 2014, January 14, 2015, February 26, 2015, and March 23, 2015, the client continued to smoke in his apartment, at times with his oxygen on. When interviewed April 14, 2015 at 11:20 a.m., C2 stated she complained about C1 smoking in	0 030		

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0 030	Continued From page 5 his apartment for approximately a year. C2 stated the smoke would go under C1's door, into the hall and under her door into her apartment. C2 stated she also would notice the smoke smell coming into her apartment through her bathroom vent. C2 stated approximately a month before the fire, she made a formal written complaint to management regarding C1's smoking and was told that they were working on it. When interviewed April 14, 2015 at 3:30 p.m., C3 stated she would notice that the hallway would have an awful cigarette smoke smell and many times she voiced concerns to the nurses related to the smoke smell. When interviewed March 31, 2015 at 10:05 a.m., licensed practical nurse (LPN)-C stated she was concerned about the safety of C1 and the other clients because of C1's smoking in his apartment and smoking in his apartment and drinking. LPN-C stated she had spoken to C1 many times related to the risk of smoking in his apartment and sometime smoking with his oxygen on. The majority of the time the unsafe smoking occurred when C1 had been drinking alcohol. When interviewed March 31, 2015 at 8:25 a.m., LPN-D stated C1 would drink and then smoke in his apartment. LPN-D stated she would document the instances of unsafe smoking and report it to the next shift. When interviewed March 30, 2015 at 3:45 p.m., LPN-E stated she was very concerned about C1 smoking in his apartment. LPN-E stated she was instructed by her supervisors that when C1 was smoking in his apartment that she was to document the non-compliance in C1's record. LPN-E stated she reported her concerns to the	0 030		

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0 030	Continued From page 6 Director of Nursing Services, the Housing Manager and the administrator of the campus. When interviewed March 31, 2015 at 1:20 p.m., LPN-G stated C1 was noncompliant with his smoking when he was drinking. LPN-G stated she was instructed by her supervisors that she should document C1's noncompliance with smoking and tell C1 not to smoke in his apartment. LPN-G stated she was concerned about the clients' safety due to C1's unsafe smoking practices. When interviewed March 30, 2015 at 10:15 a.m., unlicensed person (ULP)-H stated several times she observed C1 smoking in his apartment. ULP-H stated she would report her observations to the nurse. ULP-H stated C1 was a danger to himself and others because of his drinking and smoking. When interviewed April 14, 2015 at 10:25 a.m., the director of nursing services (DNS) was questioned as to how the facility was keeping C1 and the other clients who received services from the licensee safe with C1's non-compliance with smoking in his apartment. Starting March 11, 2015, additional safety checks of C1 were added at 11:00 p.m. and 3:00 a.m., attempts to get other agencies involved to assist, and looking for alternate placement for the client were measures taken to assist in keeping C1 and the other clients safe. The DNS stated the eviction process should have been started and C1 should have been discharged. The DNS stated C1 had the potential to be a safety concern to himself and others when he was drinking. The DNS stated when C1 was not drinking alcohol, the client would not exhibit unsafe smoking.	0 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21870	A. BUILDING: _____ B. WING _____	C 04/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY VILLA	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
0 030	Continued From page 7 When interviewed April 10, 2015 at 2:30 p.m., the assistant housing director was questioned as to how the facility was keeping C1 and the other clients in the building safe with C1's non-compliance with smoking in his apartment. The assistant housing director stated, we were looking for different opportunities for placement of C1, we called different agencies for assistance, and we increased his services. The assistant housing director acknowledged that C1 posed a safety concern to himself and others when C1 smoked in his apartment with or without his oxygen on. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 030		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H21116	A. Building B. Wing	7/29/2015

Name of Facility	Street Address, City, State, Zip Code
WOODBURY ESTATES	2825 WOODLANE DRIVE WOODBURY, MN 55125

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 00265 Reg. # 144A.44, Subd. 1(2) LSC	07/29/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/27/2015				