Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302239126M
Compliance #: HL302236807C

Date Concluded: April 9, 2024

Name, Address, and County of Licensee Investigated:
Woodbury Villa
7008 Lake Road
Woodbury, MN 55125
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN BSN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the resident was found smoking in his room with supplemental oxygen and used a lighter to light the oxygen on fire.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Through a series of unsafe smoking events by the resident, the facility failed to assess and implement interventions to prevent the resident from smoking in his room with supplemental oxygen. The resident used a lighter and lit the oxygen gas coming from the oxygen tubing causing a big flame.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed the resident. The investigation included review of the resident records, hospital records, facility internal

investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident in his apartment.

The resident resided in an assisted living facility. The resident's diagnoses included chronic obstructive pulmonary disease (COPD), depression, restlessness, and agitation. The resident's service plan included assistance with oxygen management and every two-hour safety checks. The resident's cognition was intact, and the resident smoked and used oxygen. The resident's individual abuse prevention plan indicated the resident was frustrated with not being able to buy cigarettes, and that safety checks were to ensure resident was not smoking in his room.

A progress note indicated one day the resident was smoking in his apartment. When staff told the resident not to smoke in his apartment, the resident entered another resident's apartment on the main floor of the facility and used the other resident's stove to light his cigarettes. With the lit cigarette, the resident walked through the facility. The progress note indicated staff were instructed to continue to store the resident's cigarettes at the nurse's station and provide the resident a cigarette when requested. The next day, the facility provided the resident with a "final warning" of potential eviction from the facility if the resident continued to smoke in his apartment and facility. The resident told staff he did not smoke in the apartment, the resident only "lit" the cigarettes in the apartment.

The next month, a progress note indicated administrative staff, observed the resident with "multiple" packs of cigarettes in the resident's walker. Administrative staff reminded the resident that his cigarettes were to be kept at the nurse's station. The resident grabbed each pack of cigarettes and threw them on the ground. The resident then stated "I know that! Now you can pick them up." The administrative staff picked up the cigarettes and brought them to the nurse's station.

Two months later, a facility incident report indicated the executive director had a conversation with the resident about smoking in his apartment after staff reported the smell of smoke outside the resident's apartment. During the conversation the resident removed his oxygen tubing from this nose and lit the oxygen gas on fire with a lighter causing a large flame. The resident stated it was not dangerous to smoke while on oxygen. The executive director unplugged the tubing from the oxygen tank and put out the fire. The resident was transported to the hospital for a behavior evaluation.

Hospital records indicated facility staff reported the resident was smoking in his room. When told by staff to stop smoking in his room, the resident became upset and used his lighter to light his oxygen on fire. Staff were able to control the fire and took his lighter. The hospital record indicated the resident was intoxicated. The resident stated he lit the oxygen on fire because facility staff did not believe him that oxygen was not flammable. The hospital record indicated the safety plan was for the facility staff to monitor the resident's lighter and cigarettes.

During an interview, a staff member stated when in the stairwell, she smelled cigarette smoke outside the resident's apartment. The staff member went to the resident's room, knocked on the door, entered and could smell cigarette smoke. The staff member stated the resident was on the couch, and another resident was in a wheelchair with his back to the door. The staff member told the resident they are not to be smoking in the resident's room and left the room to report to leadership. The staff member stated this was not the first conversation with the resident regarding smoking inside the facility and the resident had been directed to smoke only in the outside designated area.

During an interview, the executive director stated when notified by a staff member the resident was smoking in his apartment with oxygen, the executive director went to the apartment to have a conversation with the resident. The executive director told the resident you could blow yourself up or blow the building up. The resident took a lighter and lit the oxygen gas coming out to the tubing, on fire. The executive director ran to the oxygen concentrator, disconnected the tubing, and shut off the concentrator. The executive director stated the resident said, see, it did not blow up. The executive director informed the resident's provider who requested an evaluation of the resident for his behavior at a hospital.

During an interview, administrative staff stated before and after the incident with the resident lighting his oxygen tubing on fire there was concerns with the resident smoking.

During an interview, the resident stated he held a lighter to his oxygen tubing and lit the oxygen on fire. The resident stated the day of the incident, staff accused him of smoking in his room. The resident denied smoking in his room that day. The resident stated he lit the oxygen on fire because he wanted to show staff that oxygen would not blow up. The resident stated he currently had a lighter in his apartment.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No. Resident responsible for self.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
After the resident lit his oxygen tubing on fire, the facility initiated every two-hour safety checks, sent the resident to the hospital, initiated the resident's cigarettes and lighter would be kept at the nurse's station, and unplugged the resident's stove.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30223	A. BUILDING: _____ B. WING _____	C 03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY VILLA	7008 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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL302239126M / HL302236807C On March 12, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 66 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL302239126M / HL302236807C, tag identification 2310 and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute 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 evaluators' 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure appropriate care and services were provided based on the resident's needs and an up-to-date assessment and service plan when safe smoking interventions were not implemented for one of one resident (R1) reviewed. R1 had multiple incidences of smoking in his apartment with supplemental oxygen, and in non-designated facility. Using a lighter, R1 set fire to R1's supplemental oxygen which had the potential of causing serious injury, impairment, or death to R1, other residents, staff, and visitors of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Review of R1's medical record indicated R1's diagnoses included chronic obstructive pulmonary disease, depression, restlessness and agitation. R1's assessment dated May 30, 2023, indicated	02310		

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02310	Continued From page 2 R1 was independent with activities of daily living, R1 smoked cigarettes, and required supplemental oxygen at two liters at rest and four liters with activity through a nasal cannula. R1's medical record lacked evidence that a smoking assessment was completed during the assessment time frame. R1's individual abuse prevention plan (IAPP) dated May 30, 2023, indicated R1 had been found in the basement of the facility smoking. The licensee directed staff to provide safety checks to ensure R1 was not smoking in his apartment. A progress note dated July 10, 2023, indicated R1 was smoking in his apartment. R1 was told by staff to not smoke in his apartment. R1 took keys to another resident's apartment on the main floor, and used the resident's stove to light his cigarettes. The progress note indicated staff were to have R1 keep his cigarettes at the nurse's station and request them when he wanted to smoke. A progress note dated August 25, 2023, indicated R1 was shouting obscenities. When assistant executive director approached R1, multiple packs of cigarettes were observed in R1's walker. When R1 was reminded that the cigarettes needed to go to the nurse's station, R1 grabbed each pack of cigarettes and threw them on the ground. R1 stated "I know that, now you can pick them up". Assistant Executive Director picked up the cigarettes and brought them to the nurse's station. A Resident Incident Report dated October 19, 2023, indicated staff noticed an odor of cigarette smoke in the hallway and inside R1's room. The	02310		

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02310	Continued From page 3 executive director was notified of the concern. When the executive director entered R1's room, during discussion, R1 took the nasal cannula from his face and using a lighter, lit the oxygen coming from the nasal cannula on fire causing a large flame. The executive director unplugged the nasal cannula from the oxygen concentrator and shut off the oxygen concentrator. Emergency medical services were notified and R1 was transported to the hospital for an evaluation of R1's behaviors. A progress note dated October 20, 2023, indicated R1 agreed to keep the cigarettes and lighter at the nurse's station upon returning from the hospital. R1's service plan dated October 20, 2023, indicated R1 had safety checks every 2 hours. The service plan directed staff to ensure R1 was not smoking in his apartment. R1's service plan lacked direction for staff if R1 was found with cigarettes or lighter. A Smoking-Safely Tool dated 10/26/23, indicated R1 was safe to smoke independently in a designated area. R1's cigarettes and lighter were to be kept at the nurse's station. During an interview on March 12, 2024, at 10:41 a.m., executive director (ED)-C, stated on October 19, 2022, another staff member came out of the stairway and could smell cigarette smoke outside R1's apartment. The staff member entered R1's room, told R1 not to smoke in his room. ED-C stated she went to R1's room and told him he could not smoke in his room. R1 picked up his oxygen tubing from the coffee table, took a lighter and lit the oxygen tubing on fire and threw it back down on the coffee table. ED-C	02310		

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02310	Continued From page 4 stated she ran to the oxygen concentrator, unplugged the oxygen tubing, shut off the oxygen concentrator, and put out the fire. During an interview on March 13, 2024, at 3:14 p.m., assistant executive director AED-D stated when R1 returned from the hospital on October 19, 2023, R1 was to have his cigarettes and lighter held at the nurse's station. AED-D stated staff were to notify management if the resident had cigarettes or a lighter in his apartment or on his person during the safety checks. AED-D stated the resident's service plan lacked direction to staff to observe R1 for cigarettes and lighters during the safety checks and to report concerns to management. AED-D stated R1 did not have a smoking assessment completed prior to the incident on October 19, 2023. During an interview on March 12, 2024, at 10:00 a.m., R1 stated he held the lighter to the oxygen tubing because he wanted to show staff it would not blow up. R1 stated the facility held onto his cigarettes, however, he currently had a lighter in his apartment. The licensee did not have a smoking policy. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 5 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	