

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Woodlake Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Bass Lake Road New Hope, MN 55428	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618</p> <p>Based on observation, interview, and record review, the facility failed to immediately, but no later than two hours, report to the state agency an allegation of abuse for one of three residents (R1) reviewed for employee to resident sexual abuse.</p> <p>Findings include:</p> <p>During an observation on 11/26/24 at 10:15 a.m. R1 was in his room calling out to nurse manager (NM)-A who was walking past R1's room. R1 was heard saying they said not to take the abuse allegations lightly, so I called 911 again and they told me to call the sergeant. NM-A asked R1 if the police officer came to talk to him and R1 stated no. R1 stated he wanted that woman arrested for abuse. NM-A stated, it was not abuse. R1 stated it was sexual abuse. NM-A stated to R1 it was not sexual abuse and walked out of R1's room.</p> <p>R1's Facesheet indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of gas gangrene. R1's additional diagnoses included pathological fracture on right radius, malignant neoplasm of prostate, paranoid schizophrenia, wedge compression fracture of third lumbar vertebra, wedge compression fracture of fourth lumbar vertebra, and wedge compression fracture of fifth lumbar vertebra.</p> <p>R1's Bladder and Bowel assessment dated [DATE] indicated R1 was continent of urine and incontinent of bowel. The assessment indicated R1 used a urinal to urinate. R1 wore incontinent briefs.</p> <p>R1's Functional Abilities and Goals assessment dated [DATE] indicated R1 required substantial/maximal assistance with toileting and partial/moderate assistance with personal hygiene and transfers.</p> <p>R1's minimum data set (MDS) dated [DATE] indicated R1 had a brief interview for mental stats (BIMS) score of fifteen, which indicated R1 was cognitively intact. R1 did not have hallucinations or delusions. R1's required substantial/maximal assistance with toileting hygiene, bathing, and dressing. R1 required partial/moderate assistance with personal hygiene. R1 was frequently incontinent of her bladder, and always incontinent of his bowel. R1 had schizophrenia and was not on antipsychotic medications.</p> <p>R1's BIMS assessment dated [DATE] indicated R1 had a score of fourteen which indicated R1 was cognitively intact.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 245518	If continuation sheet Page 1 of 3

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's progress note dated 11/17/24 indicated R1 stayed in bed during the duration of shift and staff has assisted R1 with activities of daily living.</p> <p>R1's care plan dated 11/22/24 indicated R1 had activities of daily living and mobility deficit related to gas gangrene of left foot, non-weight bearing on left leg, left lower extremity cellulitis, left and right foot wounds, weakness, peripheral vascular disease, anemia, malnutrition, paranoid schizophrenia, anxiety, malignant neoplasm of prostate, prediabetes, Charcot's joint in left foot, planter callosity, pain, and lumbar wedge compression fractures. The intervention placed on 11/22/24 was cares in pairs.</p> <p>R1's care plan dated 11/25/24 indicated R1 had a history of behaviors. R1's behaviors are typically using the term abuse/hate crimes in relation to receive care such as being weighed, hair being washed/dried with hair dryer, and fixation on medical malpractice lawsuits from past hospital stays years ago. R1's behaviors are related to paranoid schizophrenia. The interventions indicated were two staff with R1 to provide cares in pairs, follow the hospital psychology services, staff would anticipate resident care needs prior to R1 becoming overly stressed and explain the cares in advanced.</p> <p>R1's progress note did not indicate R1's allegations of sexual abuse.</p> <p>During an interview on 11/26/24 at 9:13 a.m., R1 stated on 11/17/24 a nursing assistant (NA) was providing pericare when the NA grabbed on to his anus and pulled on it very hard about two to three times. R1 described the incident as a vicious and violent assault. R1 could not recall the name of the NA who assisted. R1 reported the incident to NM-A and thought NM-A had reprimanded or talked to the NA about it. R1 was unsure whether he obtained any injuries from the incident. R1 called 911 on 11/17/24 and described in detail what had happened. R1 stated the 911 operator told him to leave a message with the sergeant and the sergeant would call him back. R1 had left a message for the sergeant. R1 stated the receptionist brought R1 a note stating to call the sergeant back at the phone number provided. R1 provided the note.</p> <p>During an interview on 11/26/24 at 9:59 a.m., registered nurse (RN)-A stated she was told R1's care plan was updated with cares in pairs over the weekend because R1 stated he was not being cleaned up properly after an incontinent episode.</p> <p>During an interview on 11/26/24 at 10:25 a.m., NM-A stated she was told by R1 on 11/22/24 that an NA provided pericare after a bowel movement when the NA had wiped his anus too hard, and it was sexual assault. NM-A talked with social services director (SSD) and the director of nursing (DON) about the incident and did not report the incident to the state agency because she does not make reports to the state agency. NM-A updated R1's care plan to assist R1 in cares in pairs to protect him and protect the facility.</p> <p>During an interview on 11/26/24 at 11:14 a.m., the SSD NM-A did not report an allegation of abuse to R1 or any concern of rough cares. SSD was not informed about R1's report of sexual abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/26/24 at 11:28 a.m., the DON stated she did not get a report from NM-A regarding R1's abuse allegation. If she knew if someone reported an allegation of abuse, she would immediately report it to the state agency and complete an investigation. DON expected a NM to report to SSD, the administrator, executive director (ED), or herself about allegations of abuse. DON stated herself would report it to the state survey agency. If DON is not in the facility, she would expect any leadership to report the allegations to the state survey agency.</p> <p>During an interview on 11/26/24 at 12:31 p.m., The administrator stated he was unaware of an abuse allegation from R1 and just learning today that R1 made allegations about sexual abuse. The administrator stated he would have reported allegations of sexual abuse to the state survey agency. The administrator's expectation is that management staff does report abuse allegations to himself and then he would report the allegations to the state survey agency. The administrator stated if he is not in the facility, there is a reporting structure for notifying the state survey agency.</p> <p>During an interview on 11/26/24 at 1:05 p.m., the executive director (ED) stated all allegations of abuse should be reported to the state survey agency. If a leadership staff learned about the sexual abuse on 11/22/24, it should have been reported to the state survey agency on 11/22/24.</p> <p>During an interview on 11/26/24 at 1:57 p.m., NM-B stated if she were told about an allegation of abuse, she would tell the DON, ensure the resident is safe, place the employee of the allegation on suspension pending the investigation, educate the staff if applicable, and then interview other entities such as social services. NM-B would follow the directions of the DON. NM-B would report the allegations either within two hours or twenty-four hours depending on the allegation.</p> <p>During an interview on 11/26/24 at 2:02 a.m., DON stated she had reported the allegation to the state survey agency when she had found out about the allegations on the day of the survey, she reported the allegation to law enforcement and placed the aide on suspension pending the facility's investigation. The DON named NA-C as the aide who was involved in the incident based on R1's description.</p> <p>During an interview on 11/26/24 at 2:11 p.m., the police officer stated R1 told her he did tell NM-A about the sexual abuse allegations but could not recall when he told her. R1 told the police officer there was some sort of penetration feeling by sticking fingers into his anus.</p> <p>During an interview on 11/26/24 at 2:25 p.m., R1 stated he told NM-A about the sexual abuse because he thought she could help him. R1 only told NM-A about the incident because he was too embarrassed to notify anyone else.</p> <p>During an interview on 11/26/24 at 2:32 p.m., NA-C stated she did not recall events on 11/22/24 but recalls R1 never told her to stop providing pericare after an incontinent episode. NA-C told her he wanted to be cleaned better during pericares. NA-C stated she did not want to hurt R1 when providing pericares.</p> <p>The facility's Abuse, Neglect, and Exploitation policy and procedure dated January 2024 indicated all alleged violations would be reported to the administrator, state agency, adult protective services and to all other required agencies within specified timeframes immediately, but not later than two hours after the allegation of made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p>		