DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email on May 19, 2021

Administrator
Mtai Trillium
306 Westgate Drive, Po Box 246
Winsted, MN 55395

RE: Event ID: X0UR11

Dear Administrator:

On May 4, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. This survey found one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the survey we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the electronically delivered "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy effective May 3, 2021.

One or more of these deficiencies do not meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID):

W122 42 CFR § 483.420 Client Protections

Federal certification deficiencies are delineated on the enclosed form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC).

A PoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your PoC must:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correctionk will be completed.

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" 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

Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by June 28, 2021, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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Emailed on May 19, 2021

Administrator
Mtai Trillium
306 Westgate Drive, Po Box 246
Winsted, MN 55395

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: XOUR11

Dear Administrator:

The above facility was surveyed on April 29, 2021 through May 4, 2021 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The 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 Supervised Living Facilities.

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 and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule 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.

When all orders are corrected, the first page of the order form should be signed and returned 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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Sarah Grebenc. A written plan for correction of licensing orders is not required.

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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G467	A. BUILDING _____ B. WING _____	C 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTAI TRILLIUM	306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395

(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) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 5/3/21 to 5/4/21, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.475. The facility was in full compliance.	E 000		
W 000	INITIAL COMMENTS On 4/29/21 through 5/4/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was NOT IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. HG467009C (MN72340) was substantiated with deficiencies issued at W122 and W127. The Condition of Participation: Client Protection 42 CFR 483.420 was found not met. As a result of the investigations W149, W153 was also cited. An Immediate Jeopardy (IJ) was identified at W127 on 4/30/21, at 4:25 p.m. The IJ began in January 2021, when direct support professional (DSP)-A went outside and placed his hands in the snow and came into the house where C1 slept in his wheelchair and placed his hands on C1's back and neck to wake him up. On 4/27/21, the following was observed: DSP-A put his hands in the freezer and cupped his hands around C1's neck; DSP-A raised his fist at C1 to threaten C1 to get up; DSP-A verbally abuse C1. DSP-A was also verbally abusive to C2 on two occasions in February 2021 and March	W 000		

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

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W 000	Continued From page 1 2021. DSP-A threatened and bulled DSP-B and DSP-C not to report these incidents of abuse. The facility was informed of the IJ on 4/30/21, at 4:25 p.m. The immediate jeopardy was removed on 5/3/21, at 4:15 p.m. when the facility placed the alleged staff on administrative leave and education was provided to staff on protocols to report when staff to client altercations and abuse were alleged or occurred. A full survey was conducted for the requirements of 42 CFR 483. Subpart I, for Intermediate Care Facilities for Individuals who are Intellectually Disabled (ICF/IID) on 5/3/21 and 5/4/21. The facility was found NOT to be in compliance.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed to protect facility clients from physical and verbal abuse by direct support professional (DSP)-A for 2 of 3 clients (C1 and C2) reviewed for abuse. Findings include: See W127 for additional information: The facility failed to protect 2 of 3 clients (C1 and C2) from physical/verbal abuse by a staff member (swearing at clients, cupping hand on throat and purposefully walking up a client with ice cold	W 122		

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W 122	Continued From page 2 hands) In addition, the staff were bullied and threatened by alleged perpetrator (AP) which left incidents unreported to the state agency or the facility administration as required by law and facility policy. This resulted in an immediate jeopardy (IJ) to the health and safety of all 6 clients who resided in the home.	W 122		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to protect 2 of 3 clients (C1 and C2) from physical/verbal abuse by a staff member (swearing at clients, cupping hand on throat and purposefully walking up a client with ice cold hands) In addition, the staff were bullied and threatened by alleged perpetrator (AP) which left incidents unreported to administration and clients vulnerable to ongoing abuse for several months. This resulted in an immediate jeopardy (IJ) to the health and safety of all 6 clients who resided in the home. The IJ began on 1/2/21, when direct support professional (DSP)-A was observed going outside and placed his hands in snow, then came into the house where C1 slept in his wheelchair. DSP-A placed his cold hands on C1's back and neck to wake him up. The program supervisor and residential administrator were informed of the IJ on 4/30/21, at 4:25 p.m. The immediate jeopardy	W 127		

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W 127	Continued From page 3	W 127		

was removed on 5/3/21, at 4:15 p.m. when the facility placed the alleged staff on administrative leave and education was provided to staff on protocols of reporting staff to client altercations/abuse.

Findings include:

C1's Identification Face Sheet (IFS) dated 4/30/21, indicated he had moderate intellectual disability, had difficulty to express himself and could follow one to two step verbal commands. In addition his IFS indicated he fed himself independently with a fork and spoon and drank with a single handled mug. C1's Individual Abuse Prevention Plan (IAPP) dated 2/01/21, indicated C1 could be abused by others bigger/stronger than himself and had inability to identify potentially dangerous situations, inability to deal with verbally/physically aggressive persons and was unlikely to report abuse to appropriate persons. Staff will remove C1 from an unsafe situation. In addition the IAPP indicated he was able to report, however he may not fully remember all the details of a situation, Trillium staff were mandated reporters and will report any suspected physical abuse on [C1]'s behalf to the appropriate people.

C2's IFS dated 5/3/21, indicated she had profound intellectual disabilities, was legally blind and had generalized anxiety disorder. The IFS further indicated she was assist of one with transfers and independent to walk. C2's IAPP dated 11/04/20, indicated she had inability to identify potentially dangerous situations and verbal/physical abuse. In addition C2's IAPP indicated she would not be able to report or defend herself from abuse.

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W 127	Continued From page 4	W 127		

A Common Entry Point Intake Form dated 4/27/21, at 12:45 p.m. indicated a hospice nurse knocked at front door on 4/27/21, around lunch time and got no answer. They entered the home and heard care giver (DSP-A) say to (C1)"You are a FUCKER and "YOU ARE PISSING ME OFF, YOU NEED TO EAT". Hospice nurse observed C1 at the counter with DSP-A next to him while he ate. The group home nurse was made aware of the witnessed verbal abuse by the hospice nurse.

During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed of the incident that occurred on 4/27/21, by her supervisor and was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house to report the incident.

During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated that morning as he got up C1, who was assist of 2, DSP-A entered the room and put up his fist up to C1 and said, "you better get up or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated he told DSP-A, "Why did you have to say that to him?" and DSP-A glared at him and walked away. DSP-B then stated later that day, at lunch time, he observed DSP-A put his hands in the freezer and then cup his hands around C1's neck and C1 was upset by this and shook his head no and shrunk away from DSP-A. DSP-B stated in January 2021, he observed DSP-A put his hands in the snow and come in the house and put his hands on C1's neck and shoulders to

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W 127	Continued From page 5	W 127		

wake him up while he was in his w/c, C1 was not happy, and shook and whimpered. DSP-A looked at DSP-B and laughed. DSP-B stated there was another incident in March 2021, where he observed DSP-A punch C1's teddy bear right in front of him and said this was how to get C1 to make his bed. C1 was upset and said "No! No!" and shook his head and made his bed. DSP-B stated he was afraid to report these incident because DSP-A told DSP-B if he reported, things would happened to him. DSP-B knew he should report but felt bullied and threatened by DSP-A so did not report the incidents.

During an interview on 4/30/21, at 12:52 p.m. the company's internal investigator stated the facility completed an internal investigation of the alleged abuse reports. Through the course of the investigation of the verbal abuse on 4/27/21, they found there were other incidents by DSP-A but staff were bullied by DSP-A and did not report incidents. They should have immediately informed management so a report could be made to the state agency.

During an interview on 4/30/21, at 1:04 p.m., DSP-C stated she observed DSP-A verbally abuse C2 twice. DSP-C stated C2 was blind and assist of one but could hear and understand. DSP-C stated the first incident occurred in February 2021 while DSP-A got C2 up he said "get the fuck up" and the second one was in March 2021 when DSP-C overheard DSP-A say, "you fucking little bitch". DSP-C did not report either one of the incidents because DSP-A said, "Oh just go tell your mommy about this". DSP-C then stated her family member was the HS and felt she tried to deal with it on her own and told DSP-A to stop. She stated she was unaware of

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W 127	Continued From page 6	W 127		

the ability to make a report to the SA directly.

During interview 4/30/21, at 2:11 p.m. DSP-A stated when he assisted C1 to eat on 4/27/21, he was on his cell phone with an important phone call and he was overheard by the hospice nurse. DSP-A stated he rarely swore and he said words he normally did not say to the collision center because his car was being fixed. DSP-A stated he has never verbally or physically abused any of the clients.

A Vulnerable Adults Maltreatment Reporting and Internal Review Policy reviewed 8/2018, indicated it is the policy of Mary T. Inc. to protect the adults served by this program who are considered vulnerable to maltreatment and to require the reporting of suspected maltreatment.

The immediate jeopardy that began on 1/2/21 was removed on 5/3/21, at 4:15 p.m.. when it could be verified by interview and document review the facility had placed the alleged perpetrator on administrative leave, education was provided to staff prior to the start of their next shift, updated their protocol on when, how and who to report abuse to when staff to client altercations occurred or were alleged to occur. All staff were interviewed and asked if there were other allegations of abuse witnessed by DSP-A or any other staff. Staff were retrained on the Vulnerable Adult Maltreatment Reporting and Internal Review Policy that included both federal and state requirements for reporting. All clients in the home were evaluated for behavior change or harm. The above information was confirmed on 5/3/21, from 12:00 p.m. to 4:00 p.m. when staff, which included DSP and HS were interviewed about the knowledge of the education they

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W 127	Continued From page 7 received.	W 127		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to implement abuse policies and procedures consistent with federal regulations that direct staff to immediately report alleged staff to client abuse to State Agency (SA) for 2 of 3 clients (C1 and C2) who was verbally and physically abused by staff. Findings include: A Common Entry Point Intake Form dated 4/27/21, at 12:45 p.m. indicated a hospice nurse knocked at front door on 4/27/21, around lunch time and got no answer, entered the home and heard care giver [DSP-A] say to [C1] "You are a FUCKER and "YOU ARE PISSING ME OFF, YOU NEED TO EAT". Hospice nurse observed C1 at the counter with DSP-A next to him while he ate. The group home nurse was made aware of the witnessed verbal abuse by the hospice nurse. During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed of the incident that occurred on 4/27/21, by her supervisor and was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house. The HS	W 149		

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W 149	Continued From page 8	W 149		

stated she was off that day so she did not make a report to the state agency and was unsure who made the report.

During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated that morning as he got up C1, who was assist of 2, DSP-A entered the room and put up his fist up to C1 and said, "you better get up or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated he told DSP-A, "Why did you have to say that to him?" and DSP-A glared at him and walked away. DSP-B then stated later that day, at lunch time, he observed DSP-A put his hands in the freezer and then cup his hands around C1's neck and C1 was upset by this and shook his head no and shrinking away from DSP-A. DSP-B stated in January 2021, he observed DSP-A put his hands in the snow and come in the house and put his hands on C1's neck and shoulders to wake him up while he was in his w/c, C1 was not happy, and shook and whimpered. DSP-A looked at DSP-B and laughed. DSP-B stated there was another incident in March 2021, where he observed DSP-A punch C1's teddy bear right in front of him and said this was how you got C1 to make his bed. C1 was upset and said "No! No!" and shook his head and made his bed. DSP-B stated he was afraid to report things because DSP-A told DSP-B if he reported, things would happened to him. DSP-B felt bullied and threatened by DSP-A.

During an interview on 4/30/21, at 12:52 p.m. the company's internal investigator stated he completed the facility investigations of incidents that occurred. Through the course of the

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W 149	Continued From page 9	W 149		

investigation of the verbal abuse on 4/27/21, he found out there were other incidents and staff who were bullied by DSP-A and did not report incidents and should have immediately informed management so a report could be made to the state agency.

During an interview on 4/30/21, at 1:04 p.m., DSP-C stated she observed DSP-A verbally abuse C2 twice. DSP-C stated C2 was blind and assist of one but could hear and understand. DSP-C stated the first incident occurred in February 2021 while DSP-A got C2 up he said "get the fuck up" and the second one was in March 2021 when DSP-C overheard DSP-A say, "you fucking little bitch". DSP-C did not report either one of the incidents because DSP-A said, "Oh just go tell your mommy about this". DSP-C then stated her mother was the HS and felt she tried to deal with it on her own and told DSP-A to stop. She stated she was unaware of the ability to make a report to the SA directly.

During an interview on 5/3/21, at 10:00 a.m. licensed practical nurse (LPN)-A stated she was informed by the hospice nurse of the incident with DSP-A and C1 on 4/27/21, and usually did not receive the calls about any incidents and did not make a report to the state agency and did not know she needed to.

During interview 5/3/21, at 12:00 p.m. residential administrator stated these incidents should have been reported to the stated agency immediately by the facility.

A Vulnerable Adults Maltreatment Reporting and Internal Review Policy reviewed 8/2018, indicated it is the policy of Mary T. Inc to protect the adults

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	24G467	A. BUILDING _____ B. WING _____	C 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTAI TRILLIUM	306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395

(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) COMPLETION DATE
W 149	Continued From page 10 served by this program who are considered vulnerable to maltreatment and to require the reporting of suspected maltreatment. In addition the report indicated you must report immediately.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the designated State Agency (SA) for 2 of 3 clients (C1 and C2) reviewed for allegations of abuse. Findings include: C1's Identification Face Sheet (IFS) dated 4/30/21, indicated he had moderate intellectual disability, had difficulty to express himself and could follow one to two step verbal commands. In addition his IFS indicated he fed himself independently with a fork and spoon and drank with a single handled mug. C1's Individual Abuse Prevention Plan (IAPP) dated 2/01/21, indicated C1 could be abused by others bigger/stronger than himself and had inability to identify potentially dangerous situations, inability to deal with verbally/physically aggressive persons and was unlikely to report abuse to appropriate persons.	W 153		

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W 153	Continued From page 11	W 153		

C2's IFS dated 5/3/21, indicated she had profound intellectual disabilities, was legally blind and had generalized anxiety disorder. The IFS further indicated she was assist of one with transfers and independent to walk. C2's IAPP dated 11/04/20, indicated she had inability to identify potentially dangerous situations and verbal/physical abuse. In addition C2's IAPP indicated she would not be able to report or defend herself from maltreatment.

A Common Entry Point Intake Form dated 4/27/21, at 12:45 p.m. indicated a hospice nurse knocked at front door on 4/27/21, around lunch time and got no answer, entered the home and heard care giver [DSP-A] say to [C1] "You are a FUCKER and "YOU ARE PISSING ME OFF, YOU NEED TO EAT". Hospice nurse observed C1 at the counter with DSP-A next to him while he ate. The group home nurse was made aware of the witnessed verbal abuse by the hospice nurse.

During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed of the incident that occurred on 4/27/21, by her supervisor and was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house. The HS stated she was off that day so she did not make a report to the state agency and was unsure who made the report.

During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated that morning as he got up C1, who was assist of 2, DSP-A

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W 153	Continued From page 12	W 153		

entered the room and put up his fist up to C1 and said, "you better get up or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated he told DSP-A, "Why did you have to say that to him?" and DSP-A glared at him and walked away. DSP-B then stated later that day, at lunch time, he observed DSP-A put his hands in the freezer and then cup his hands around C1's neck and C1 was upset by this and shook his head no and shrinking away from DSP-A. DSP-B stated in January 2021, he observed DSP-A put his hands in the snow and come in the house and put his hands on C1's neck and shoulders to wake him up while he was in his w/c, C1 was not happy, and shook and whimpered. DSP-A looked at DSP-B and laughed. DSP-B stated there was another incident in March 2021, where he observed DSP-A punch C1's teddy bear right in front of him and said this was how you got C1 to make his bed. C1 was upset and said "No! No!" and shook his head and made his bed. DSP-B stated he was afraid to report things because DSP-A told DSP-B if he reported, things would happened to him. DSP-B felt bullied and threatened by DSP-A.

During an interview on 4/30/21, at 12:52 p.m. the company's internal investigator stated he completed the facility investigations of incidents that occurred. Through the course of the investigation of the verbal abuse on 4/27/21, he found out there were other incidents and staff who were bullied by DSP-A and did not report incidents and should have immediately informed management so a report could be made to the state agency.

During an interview on 4/30/21, at 1:04 p.m., DSP-C stated she observed DSP-A verbally

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W 153	Continued From page 13 abuse C2 twice. DSP-C stated C2 was blind and assist of one but could hear and understand. DSP-C stated the first incident occurred in February 2021 while DSP-A got C2 up he said "get the fuck up" and the second one was in March 2021 when DSP-C overheard DSP-A say, "you fucking little bitch". DSP-C did not report either one of the incidents because DSP-A said, "Oh just go tell your mommy about this". DSP-C then stated her mother was the HS and felt she tried to deal with it on her own and told DSP-A to stop. She stated she was unaware of the ability to make a report to the SA directly. During an interview on 5/3/21, at 10:00 a.m. licensed practical nurse (LPN)-A stated she was informed by the hospice nurse of the incident with DSP-A and C1 on 4/27/21, and usually did not receive the calls about any incidents and did not make a report to the state agency and did not know she needed to. During an interview on 5/3/21, at 12:00 p.m. residential administrator stated these incidents should have been reported to the stated agency immediately by the facility. A Vulnerable Adults Maltreatment Reporting and Internal Review Policy reviewed 8/2018, indicated it was the policy of Mary T. Inc to protect the adults served by this program who are considered vulnerable to maltreatment and to require the reporting of suspected maltreatment. In addition the report indicated you must report immediately.	W 153		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2)	W 369		

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W 369	Continued From page 14 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered separately via gastric tube (GT) to prevent potential adverse interactions in accordance to acceptable professional standards for 2 of 6 clients (C6 and C4) reviewed for medication administration. Findings include: C6's Identification Face Sheet dated 4/3/2021, indicated she had profound intellectual disability and was fed through a G-tube and did not take anything by mouth due to aspiration risk. During observation of medication pass on 5/4/2021, at 8:11 a.m., direct support professional (DSP)-D was observed to set up C6's medications. DSP-D opened a bottle of tegretol (antiseizure medication) and poured 10 millimeters (ml) into a clear medication cup, and then poured into a Pyrex measuring cup that contained a cup of water. DSP-D then proceeded to pour 4 ml Lasix (diuretic) and 1 scoop of beneprotein (protein powder) and poured into the cup of water and mixed them all together. DSP-D then entered C6's room. Flushed 125 ml of water into G-tube by gravity flow, then gave medications together mixed in 1 cup of water by gravity and followed 125 ml of water. During interview 5/4/2021, at 8:30 a.m. DSP-D stated the facility licensed practical nurse (LPN)-A	W 369		

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instructed her it was "ok to give all of the medications together".

C4's Identification Face Sheet dated 4/30/2021, indicated she was profound intellectual disabled and was gastric tube fed due to failure to thrive.

C4's current signed physician orders dated 10/05/2020, indicated she received fiber laxative one tablet daily, prevacid 30 milligram (mg) capsule daily, levetiracetam (anticonvulsant) 15 ml daily, Zyprexa (antipsychotic) 7.5 mg daily, ondansetron (prevent nausea) 4 mg daily.

During interview 5/4/2021, at 9:00 a.m. program manager (PM) stated C6 and C4 both have G-tubes and received all of their medications through the G-tube and all at once. The PM further stated she was instructed by the facility LPN-A the procedure was to give them together.

During interview 5/4/2021, at , at 9:21 a.m. Geritom pharmacy consultant (Pharm)-C stated he was not aware the staff gave the medications together. Pharm-C then stated it was a standard of practice to give medications by G-tube one at a time due to the potential for an adverse reaction.

During interview 5/4/2021, at 10:15 a.m. LPN-A stated she was unaware medications should not be given all together since they all go into the stomach.

Facility procedure Gastrostomy Tube Feeding Care undated, indicated Giving the Medication "Check with the pharmacists or nurse to be sure that the pills may be crushed and given at the same time. Also check with pharmacy to see if capsules with powder content can be opened and

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W 369	Continued From page 16 dissolved." Although the facility procedure indicated to check with the pharmacist or nurse to give medications at the same time, DSP-D gave medications together.	W 369		

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	01614	A. BUILDING: _____ B. WING _____	C 05/04/2021

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. On 4/29/21 through 5/4/21, surveyor of this Department visited the above provider and the following correction order was issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to: Minnesota Department of Health Health Regulation Division Licensing and Certification Program 85 East 7th Place	5 000	In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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.	

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

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5 000	Continued From page 1 Suite 220 Attention: Sarah Grebenc St Paul MN 55164 or email Sarah Grebenc at sarah.grebenc@state.mn.us	5 000	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 or MN Statute indicated below. When a rule or statute 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.	
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has	5 815		

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5 815	Continued From page 2	5 815		

reason to believe the vulnerable adult was maltreated in the previous facility; or
(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).
(b) A person not required to report under the provisions of this section may voluntarily report as described above.
(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.
(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.
(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to immediately report allegations of abuse to the designated State Agency (SA) for 2 of 3 clients (C1 and C2) reviewed for allegations

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5 815	Continued From page 3 of abuse. Findings include: C1's Identification Face Sheet (IFS) dated 4/30/21, indicated he had moderate intellectual disability, had difficulty to express himself and could follow one to two step verbal commands. In addition his IFS indicated he fed himself independently with a fork and spoon and drank with a single handled mug. C1's Individual Abuse Prevention Plan (IAPP) dated 2/01/21, indicated C1 could be abused by others bigger/stronger than himself and had inability to identify potentially dangerous situations, inability to deal with verbally/physically aggressive persons and was unlikely to report abuse to appropriate persons. C2's IFS dated 5/3/21, indicated she had profound intellectual disabilities, was legally blind and had generalized anxiety disorder. The IFS further indicated she was assist of one with transfers and independent to walk. C2's IAPP dated 11/04/20, indicated she had inability to identify potentially dangerous situations and verbal/physical abuse. In addition C2's IAPP indicated she would not be able to report or defend herself from maltreatment. A Common Entry Point Intake Form dated 4/27/21, at 12:45 p.m. indicated a hospice nurse knocked at front door on 4/27/21, around lunch time and got no answer, entered the home and heard care giver [DSP-A] say to [C1] "You are a FUCKER and "YOU ARE PISSING ME OFF, YOU NEED TO EAT". Hospice nurse observed C1 at the counter with DSP-A next to him while he ate. The group home nurse was made aware of the witnessed verbal abuse by the hospice nurse.	5 815		

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5 815	Continued From page 4 During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed of the incident that occurred on 4/27/21, by her supervisor and was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house. The HS stated she was off that day so she did not make a report to the state agency and was unsure who made the report. During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated that morning as he got up C1, who was assist of 2, DSP-A entered the room and put up his fist up to C1 and said, "you better get up or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated he told DSP-A, "Why did you have to say that to him?" and DSP-A glared at him and walked away. DSP-B then stated later that day, at lunch time, he observed DSP-A put his hands in the freezer and then cup his hands around C1's neck and C1 was upset by this and shook his head no and shrinking away from DSP-A. DSP-B stated in January 2021, he observed DSP-A put his hands in the snow and come in the house and put his hands on C1's neck and shoulders to wake him up while he was in his w/c, C1 was not happy, and shook and whimpered. DSP-A looked at DSP-B and laughed. DSP-B stated there was another incident in March 2021, where he observed DSP-A punch C1's teddy bear right in front of him and said this was how you got C1 to make his bed. C1 was upset and said "No! No!" and shook his head and made his bed. DSP-B stated he was afraid to report things because DSP-A told DSP-B if he reported, things would	5 815		

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5 815	Continued From page 5	5 815		

happened to him. DSP-B felt bullied and threatened by DSP-A.

During an interview on 4/30/21, at 12:52 p.m. the company's internal investigator stated he completed the facility investigations of incidents that occurred. Through the course of the investigation of the verbal abuse on 4/27/21, he found out there were other incidents and staff who were bullied by DSP-A and did not report incidents and should have immediately informed management so a report could be made to the state agency.

During an interview on 4/30/21, at 1:04 p.m., DSP-C stated she observed DSP-A verbally abuse C2 twice. DSP-C stated C2 was blind and assist of one but could hear and understand. DSP-C stated the first incident occurred in February 2021 while DSP-A got C2 up he said "get the fuck up" and the second one was in March 2021 when DSP-C overheard DSP-A say, "you fucking little bitch". DSP-C did not report either one of the incidents because DSP-A said, "Oh just go tell your mommy about this". DSP-C then stated her mother was the HS and felt she tried to deal with it on her own and told DSP-A to stop. She stated she was unaware of the ability to make a report to the SA directly.

During an interview on 5/3/21, at 10:00 a.m. licensed practical nurse (LPN)-A stated she was informed by the hospice nurse of the incident with DSP-A and C1 on 4/27/21, and usually did not receive the calls about any incidents and did not make a report to the state agency and did not know she needed to.

During an interview on 5/3/21, at 12:00 p.m. residential administrator stated these incidents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01614	A. BUILDING: _____ B. WING _____	C 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTAI TRILLIUM	**306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395**

(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
5 815	Continued From page 6 should have been reported to the stated agency immediately by the facility. A Vulnerable Adults Maltreatment Reporting and Internal Review Policy reviewed 8/2018, indicated it was the policy of Mary T. Inc to protect the adults served by this program who are considered vulnerable to maltreatment and to require the reporting of suspected maltreatment. In addition the report indicated you must report immediately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G467	A. BUILDING _____ B. WING _____	C 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 5/3/21 to 5/4/21, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.475. The facility was in full compliance.	E 000	accepted and approved 6/4/21 SG	
W 000	INITIAL COMMENTS On 4/29/21 through 5/4/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was NOT IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. HG467009C (MN72340) was substantiated with deficiencies issued at W122 and W127. The Condition of Participation: Client Protection 42 CFR 483.420 was found not met. As a result of the investigations W149, W153 was also cited. An Immediate Jeopardy (IJ) was identified at W127 on 4/30/21, at 4:25 p.m. The IJ began in January 2021, when direct support professional (DSP)-A went outside and placed his hands in the snow and came into the house where C1 slept in his wheelchair and placed his hands on C1's back and neck to wake him up. On 4/27/21, the following was observed: DSP-A put his hands in the freezer and cupped his hands around C1's neck; DSP-A raised his fist at C1 to threaten C1 to get up; DSP-A verbally abuse C1. DSP-A was also verbally abusive to C2 on two occasions in February 2021 and March	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cathy Hanson, RA
TITLE: Residential Admininstrator
(X6) DATE: 6/3/2021

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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W 000	Continued From page 1 2021. DSP-A threatened and bulled DSP-B and DSP-C not to report these incidents of abuse. The facility was informed of the IJ on 4/30/21, at 4:25 p.m. The immediate jeopardy was removed on 5/3/21, at 4:15 p.m. when the facility placed the alleged staff on administrative leave and education was provided to staff on protocols to report when staff to client altercations and abuse were alleged or occurred. A full survey was conducted for the requirements of 42 CFR 483. Subpart I, for Intermediate Care Facilities for Individuals who are Intellectually Disabled (ICF/IID) on 5/3/21 and 5/4/21. The facility was found NOT to be in compliance.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed to protect facility clients from physical and verbal abuse by direct support professional (DSP)-A for 2 of 3 clients (C1 and C2) reviewed for abuse. Findings include: See W127 for additional information: The facility failed to protect 2 of 3 clients (C1 and C2) from physical/verbal abuse by a staff member (swearing at clients, cupping hand on throat and purposefully walking up a client with ice cold	W 122	W122: The AP was removed from the schedule immediately upon management being aware of the accusations. After investigation the AP was removed from employment. All staff were retrained on the Vulnerable Adults Maltreatment Reporting and Internal Review Policy. The training included definitions of maltreatment and the obligation of reporting. This policy includes both federal and state reporting requirements. Additionally, the staff that were aware or witness of the AP's actions have received documented individual counseling on their responsibility as a mandated reporter. The Designated Manager will monitor for compliance by randomly talking with staff and asking if they have any concerns. Correction date: 5/7/2021	

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W 122	Continued From page 2 hands) In addition, the staff were bullied and threatened by alleged perpetrator (AP) which left incidents unreported to the state agency or the facility administration as required by law and facility policy. This resulted in an immediate jeopardy (IJ) to the health and safety of all 6 clients who resided in the home.	W 122		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to protect 2 of 3 clients (C1 and C2) from physical/verbal abuse by a staff member (swearing at clients, cupping hand on throat and purposefully walking up a client with ice cold hands) In addition, the staff were bullied and threatened by alleged perpetrator (AP) which left incidents unreported to administration and clients vulnerable to ongoing abuse for several months. This resulted in an immediate jeopardy (IJ) to the health and safety of all 6 clients who resided in the home. The IJ began on 1/2/21, when direct support professional (DSP)-A was observed going outside and placed his hands in snow, then came into the house where C1 slept in his wheelchair. DSP-A placed his cold hands on C1's back and neck to wake him up. The program supervisor and residential administrator were informed of the IJ on 4/30/21, at 4:25 p.m. The immediate jeopardy	W 127	W 127: The AP was removed from the schedule immediately upon management being aware of the accusations. After investigation the AP was removed from employment. All staff were retrained on the Vulnerable Adults Maltreatment Reporting and Internal Review Policy. The training included definitions of maltreatment and the obligation of reporting. This policy includes both federal and state reporting requirements. Additionally, the staff that were aware or witness of the AP's actions have received documented individual counseling on their responsibility as a mandated reporter. The Designated Manager will monitor for compliance. Correction date: 5/7/2021	

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W 127	Continued From page 3 was removed on 5/3/21, at 4:15 p.m. when the facility placed the alleged staff on administrative leave and education was provided to staff on protocols of reporting staff to client altercations/abuse. Findings include: C1's Identification Face Sheet (IFS) dated 4/30/21, indicated he had moderate intellectual disability, had difficulty to express himself and could follow one to two step verbal commands. In addition his IFS indicated he fed himself independently with a fork and spoon and drank with a single handled mug. C1's Individual Abuse Prevention Plan (IAPP) dated 2/01/21, indicated C1 could be abused by others bigger/stronger than himself and had inability to identify potentially dangerous situations, inability to deal with verbally/physically aggressive persons and was unlikely to report abuse to appropriate persons. Staff will remove C1 from an unsafe situation. In addition the IAPP indicated he was able to report, however he may not fully remember all the details of a situation, Trillium staff were mandated reporters and will report any suspected physical abuse on [C1]'s behalf to the appropriate people. C2's IFS dated 5/3/21, indicated she had profound intellectual disabilities, was legally blind and had generalized anxiety disorder. The IFS further indicated she was assist of one with transfers and independent to walk. C2's IAPP dated 11/04/20, indicated she had inability to identify potentially dangerous situations and verbal/physical abuse. In addition C2's IAPP indicated she would not be able to report or defend herself from abuse.	W 127		

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W 127	Continued From page 4 A Common Entry Point Intake Form dated 4/27/21, at 12:45 p.m. indicated a hospice nurse knocked at front door on 4/27/21, around lunch time and got no answer. They entered the home and heard care giver (DSP-A) say to (C1)"You are a FUCKER and "YOU ARE PISSING ME OFF, YOU NEED TO EAT". Hospice nurse observed C1 at the counter with DSP-A next to him while he ate. The group home nurse was made aware of the witnessed verbal abuse by the hospice nurse. During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed of the incident that occurred on 4/27/21, by her supervisor and was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house to report the incident. During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated that morning as he got up C1, who was assist of 2, DSP-A entered the room and put up his fist up to C1 and said, "you better get up or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated he told DSP-A, "Why did you have to say that to him?" and DSP-A glared at him and walked away. DSP-B then stated later that day, at lunch time, he observed DSP-A put his hands in the freezer and then cup his hands around C1's neck and C1 was upset by this and shook his head no and shrunk away from DSP-A. DSP-B stated in January 2021, he observed DSP-A put his hands in the snow and come in the house and put his hands on C1's neck and shoulders to	W 127		

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W 127	Continued From page 5 wake him up while he was in his w/c, C1 was not happy, and shook and whimpered. DSP-A looked at DSP-B and laughed. DSP-B stated there was another incident in March 2021, where he observed DSP-A punch C1's teddy bear right in front of him and said this was how to get C1 to make his bed. C1 was upset and said "No! No!" and shook his head and made his bed. DSP-B stated he was afraid to report these incident because DSP-A told DSP-B if he reported, things would happened to him. DSP-B knew he should report but felt bullied and threatened by DSP-A so did not report the incidents. During an interview on 4/30/21, at 12:52 p.m. the company's internal investigator stated the facility completed an internal investigation of the alleged abuse reports. Through the course of the investigation of the verbal abuse on 4/27/21, they found there were other incidents by DSP-A but staff were bullied by DSP-A and did not report incidents. They should have immediately informed management so a report could be made to the state agency. During an interview on 4/30/21, at 1:04 p.m., DSP-C stated she observed DSP-A verbally abuse C2 twice. DSP-C stated C2 was blind and assist of one but could hear and understand. DSP-C stated the first incident occurred in February 2021 while DSP-A got C2 up he said "get the fuck up" and the second one was in March 2021 when DSP-C overheard DSP-A say, "you fucking little bitch". DSP-C did not report either one of the incidents because DSP-A said, "Oh just go tell your mommy about this". DSP-C then stated her family member was the HS and felt she tried to deal with it on her own and told DSP-A to stop. She stated she was unaware of	W 127		

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W 127	Continued From page 6 the ability to make a report to the SA directly. During interview 4/30/21, at 2:11 p.m. DSP-A stated when he assisted C1 to eat on 4/27/21, he was on his cell phone with an important phone call and he was overheard by the hospice nurse. DSP-A stated he rarely swore and he said words he normally did not say to the collision center because his car was being fixed. DSP-A stated he has never verbally or physically abused any of the clients. A Vulnerable Adults Maltreatment Reporting and Internal Review Policy reviewed 8/2018, indicated it is the policy of Mary T. Inc. to protect the adults served by this program who are considered vulnerable to maltreatment and to require the reporting of suspected maltreatment. The immediate jeopardy that began on 1/2/21 was removed on 5/3/21, at 4:15 p.m.. when it could be verified by interview and document review the facility had placed the alleged perpetrator on administrative leave, education was provided to staff prior to the start of their next shift, updated their protocol on when, how and who to report abuse to when staff to client altercations occurred or were alleged to occur. All staff were interviewed and asked if there were other allegations of abuse witnessed by DSP-A or any other staff. Staff were retrained on the Vulnerable Adult Maltreatment Reporting and Internal Review Policy that included both federal and state requirements for reporting. All clients in the home were evaluated for behavior change or harm. The above information was confirmed on 5/3/21, from 12:00 p.m. to 4:00 p.m. when staff, which included DSP and HS were interviewed about the knowledge of the education they	W 127		

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W 127	Continued From page 7 received.	W 127		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to implement abuse policies and procedures consistent with federal regulations that direct staff to immediately report alleged staff to client abuse to State Agency (SA) for 2 of 3 clients (C1 and C2) who was verbally and physically abused by staff. Findings include: A Common Entry Point Intake Form dated 4/27/21, at 12:45 p.m. indicated a hospice nurse knocked at front door on 4/27/21, around lunch time and got no answer, entered the home and heard care giver [DSP-A] say to [C1] "You are a FUCKER and "YOU ARE PISSING ME OFF, YOU NEED TO EAT". Hospice nurse observed C1 at the counter with DSP-A next to him while he ate. The group home nurse was made aware of the witnessed verbal abuse by the hospice nurse. During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed of the incident that occurred on 4/27/21, by her supervisor and was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house. The HS	W 149	W149: The AP was removed from the schedule immediately upon management being aware of the accusations. After investigation the AP was removed from employment. All staff were retrained on the Vulnerable Adults Maltreatment Reporting and Internal Review Policy. The training included definitions of maltreatment and the obligation of reporting. This policy includes both federal and state reporting requirements. Additionally, the staff that were aware or witness of the AP's actions have received documented individual counseling on their responsibility as a mandated reporter. The Designated Manager will monitor for compliance by randomly talking with staff and asking if they have any concerns. Correction date: 5/7/2021	

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W 149	Continued From page 8 stated she was off that day so she did not make a report to the state agency and was unsure who made the report. During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated that morning as he got up C1, who was assist of 2, DSP-A entered the room and put up his fist up to C1 and said, "you better get up or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated he told DSP-A, "Why did you have to say that to him?" and DSP-A glared at him and walked away. DSP-B then stated later that day, at lunch time, he observed DSP-A put his hands in the freezer and then cup his hands around C1's neck and C1 was upset by this and shook his head no and shrinking away from DSP-A. DSP-B stated in January 2021, he observed DSP-A put his hands in the snow and come in the house and put his hands on C1's neck and shoulders to wake him up while he was in his w/c, C1 was not happy, and shook and whimpered. DSP-A looked at DSP-B and laughed. DSP-B stated there was another incident in March 2021, where he observed DSP-A punch C1's teddy bear right in front of him and said this was how you got C1 to make his bed. C1 was upset and said "No! No!" and shook his head and made his bed. DSP-B stated he was afraid to report things because DSP-A told DSP-B if he reported, things would happened to him. DSP-B felt bullied and threatened by DSP-A. During an interview on 4/30/21, at 12:52 p.m. the company's internal investigator stated he completed the facility investigations of incidents that occurred. Through the course of the	W 149		

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W 149	Continued From page 9 investigation of the verbal abuse on 4/27/21, he found out there were other incidents and staff who were bullied by DSP-A and did not report incidents and should have immediately informed management so a report could be made to the state agency. During an interview on 4/30/21, at 1:04 p.m., DSP-C stated she observed DSP-A verbally abuse C2 twice. DSP-C stated C2 was blind and assist of one but could hear and understand. DSP-C stated the first incident occurred in February 2021 while DSP-A got C2 up he said "get the fuck up" and the second one was in March 2021 when DSP-C overheard DSP-A say, "you fucking little bitch". DSP-C did not report either one of the incidents because DSP-A said, "Oh just go tell your mommy about this". DSP-C then stated her mother was the HS and felt she tried to deal with it on her own and told DSP-A to stop. She stated she was unaware of the ability to make a report to the SA directly. During an interview on 5/3/21, at 10:00 a.m. licensed practical nurse (LPN)-A stated she was informed by the hospice nurse of the incident with DSP-A and C1 on 4/27/21, and usually did not receive the calls about any incidents and did not make a report to the state agency and did not know she needed to. During interview 5/3/21, at 12:00 p.m. residential administrator stated these incidents should have been reported to the stated agency immediately by the facility. A Vulnerable Adults Maltreatment Reporting and Internal Review Policy reviewed 8/2018, indicated it is the policy of Mary T. Inc to protect the adults	W 149		

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W 149	Continued From page 10 served by this program who are considered vulnerable to maltreatment and to require the reporting of suspected maltreatment. In addition the report indicated you must report immediately.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the designated State Agency (SA) for 2 of 3 clients (C1 and C2) reviewed for allegations of abuse. Findings include: C1's Identification Face Sheet (IFS) dated 4/30/21, indicated he had moderate intellectual disability, had difficulty to express himself and could follow one to two step verbal commands. In addition his IFS indicated he fed himself independently with a fork and spoon and drank with a single handled mug. C1's Individual Abuse Prevention Plan (IAPP) dated 2/01/21, indicated C1 could be abused by others bigger/stronger than himself and had inability to identify potentially dangerous situations, inability to deal with verbally/physically aggressive persons and was unlikely to report abuse to appropriate persons.	W 153	W 153 Effective immediately and on an on-going basis, all allegations of mistreatment, neglect, or abuse will be immediately reported to the Administer or the state agency directly. The Administrator will assure that State Agency be contacted as required. Direct Service Professionals and Service Coordinator were provided additional training on VA policy, which includes the immediacy of reporting all accusations of suspected abuse or neglect, injuries of unknown origin or any significant medication error to the Administrator and/or to MAARC. The Designated Manager will monitor for compliance. Completion date: 5/4/2021	

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	24G467	A. BUILDING _____ B. WING _____	C 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTAI TRILLIUM	306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395

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W 153	Continued From page 11 C2's IFS dated 5/3/21, indicated she had profound intellectual disabilities, was legally blind and had generalized anxiety disorder. The IFS further indicated she was assist of one with transfers and independent to walk. C2's IAPP dated 11/04/20, indicated she had inability to identify potentially dangerous situations and verbal/physical abuse. In addition C2's IAPP indicated she would not be able to report or defend herself from maltreatment. A Common Entry Point Intake Form dated 4/27/21, at 12:45 p.m. indicated a hospice nurse knocked at front door on 4/27/21, around lunch time and got no answer, entered the home and heard care giver [DSP-A] say to [C1] "You are a FUCKER and "YOU ARE PISSING ME OFF, YOU NEED TO EAT". Hospice nurse observed C1 at the counter with DSP-A next to him while he ate. The group home nurse was made aware of the witnessed verbal abuse by the hospice nurse. During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed of the incident that occurred on 4/27/21, by her supervisor and was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house. The HS stated she was off that day so she did not make a report to the state agency and was unsure who made the report. During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated that morning as he got up C1, who was assist of 2, DSP-A	W 153		

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W 153	Continued From page 12 entered the room and put up his fist up to C1 and said, "you better get up or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated he told DSP-A, "Why did you have to say that to him?" and DSP-A glared at him and walked away. DSP-B then stated later that day, at lunch time, he observed DSP-A put his hands in the freezer and then cup his hands around C1's neck and C1 was upset by this and shook his head no and shrinking away from DSP-A. DSP-B stated in January 2021, he observed DSP-A put his hands in the snow and come in the house and put his hands on C1's neck and shoulders to wake him up while he was in his w/c, C1 was not happy, and shook and whimpered. DSP-A looked at DSP-B and laughed. DSP-B stated there was another incident in March 2021, where he observed DSP-A punch C1's teddy bear right in front of him and said this was how you got C1 to make his bed. C1 was upset and said "No! No!" and shook his head and made his bed. DSP-B stated he was afraid to report things because DSP-A told DSP-B if he reported, things would happened to him. DSP-B felt bullied and threatened by DSP-A. During an interview on 4/30/21, at 12:52 p.m. the company's internal investigator stated he completed the facility investigations of incidents that occurred. Through the course of the investigation of the verbal abuse on 4/27/21, he found out there were other incidents and staff who were bullied by DSP-A and did not report incidents and should have immediately informed management so a report could be made to the state agency. During an interview on 4/30/21, at 1:04 p.m., DSP-C stated she observed DSP-A verbally	W 153		

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W 153	Continued From page 13 abuse C2 twice. DSP-C stated C2 was blind and assist of one but could hear and understand. DSP-C stated the first incident occurred in February 2021 while DSP-A got C2 up he said "get the fuck up" and the second one was in March 2021 when DSP-C overheard DSP-A say, "you fucking little bitch". DSP-C did not report either one of the incidents because DSP-A said, "Oh just go tell your mommy about this". DSP-C then stated her mother was the HS and felt she tried to deal with it on her own and told DSP-A to stop. She stated she was unaware of the ability to make a report to the SA directly. During an interview on 5/3/21, at 10:00 a.m. licensed practical nurse (LPN)-A stated she was informed by the hospice nurse of the incident with DSP-A and C1 on 4/27/21, and usually did not receive the calls about any incidents and did not make a report to the state agency and did not know she needed to. During an interview on 5/3/21, at 12:00 p.m. residential administrator stated these incidents should have been reported to the stated agency immediately by the facility. A Vulnerable Adults Maltreatment Reporting and Internal Review Policy reviewed 8/2018, indicated it was the policy of Mary T. Inc to protect the adults served by this program who are considered vulnerable to maltreatment and to require the reporting of suspected maltreatment. In addition the report indicated you must report immediately.	W 153		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2)	W 369		

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W 369	Continued From page 14 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered separately via gastric tube (GT) to prevent potential adverse interactions in accordance to acceptable professional standards for 2 of 6 clients (C6 and C4) reviewed for medication administration. Findings include: C6's Identification Face Sheet dated 4/3/2021, indicated she had profound intellectual disability and was fed through a G-tube and did not take anything by mouth due to aspiration risk. During observation of medication pass on 5/4/2021, at 8:11 a.m., direct support professional (DSP)-D was observed to set up C6's medications. DSP-D opened a bottle of tegretol (antiseizure medication) and poured 10 millimeters (ml) into a clear medication cup, and then poured into a Pyrex measuring cup that contained a cup of water. DSP-D then proceeded to pour 4 ml Lasix (diuretic) and 1 scoop of beneprotein (protein powder) and poured into the cup of water and mixed them all together. DSP-D then entered C6's room. Flushed 125 ml of water into G-tube by gravity flow, then gave medications together mixed in 1 cup of water by gravity and followed 125 ml of water. During interview 5/4/2021, at 8:30 a.m. DSP-D stated the facility licensed practical nurse (LPN)-A	W 369	The program LPN consulted with the primary physicians of C6 and C4. The physician ordered that the medications could be given via G-tube at the same time. Going forward, if new Gtube orders are recieved, or meds are changed for the current residents on gtubes, the LPN will consult with the physician for instructions. The RN will monitor for complaince. Correction date: 5/7/2021	

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W 369	Continued From page 15 instructed her it was "ok to give all of the medications together". C4's Identification Face Sheet dated 4/30/2021, indicated she was profound intellectual disabled and was gastric tube fed due to failure to thrive. C4's current signed physician orders dated 10/05/2020, indicated she received fiber laxative one tablet daily, prevacid 30 milligram (mg) capsule daily, levetiracetam (anticonvulsant) 15 ml daily, Zyprexa (antipsychotic) 7.5 mg daily, ondansetron (prevent nausea) 4 mg daily. During interview 5/4/2021, at 9:00 a.m. program manager (PM) stated C6 and C4 both have G-tubes and received all of their medications through the G-tube and all at once. The PM further stated she was instructed by the facility LPN-A the procedure was to give them together. During interview 5/4/2021, at , at 9:21 a.m. Geritom pharmacy consultant (Pharm)-C stated he was not aware the staff gave the medications together. Pharm-C then stated it was a standard of practice to give medications by G-tube one at a time due to the potential for an adverse reaction. During interview 5/4/2021, at 10:15 a.m. LPN-A stated she was unaware medications should not be given all together since they all go into the stomach. Facility procedure Gastrostomy Tube Feeding Care undated, indicated Giving the Medication "Check with the pharmacists or nurse to be sure that the pills may be crushed and given at the same time. Also check with pharmacy to see if capsules with powder content can be opened and	W 369		

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W 369	Continued From page 16 dissolved." Although the facility procedure indicated to check with the pharmacist or nurse to give medications at the same time, DSP-D gave medications together.	W 369		

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. On 4/29/21 through 5/4/21, surveyor of this Department visited the above provider and the following correction order was issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to: Minnesota Department of Health Health Regulation Division Licensing and Certification Program 85 East 7th Place	5 000	In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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.	

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5 000	Continued From page 1 Suite 220 Attention: Sarah Grebenc St Paul MN 55164 or email Sarah Grebenc at sarah.grebenc@state.mn.us	5 000	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 or MN Statute indicated below. When a rule or statute 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.	
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has	5 815		

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5 815	Continued From page 2 reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the designated State Agency (SA) for 2 of 3 clients (C1 and C2) reviewed for allegations	5 815		

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5 815	Continued From page 3 of abuse. Findings include: C1's Identification Face Sheet (IFS) dated 4/30/21, indicated he had moderate intellectual disability, had difficulty to express himself and could follow one to two step verbal commands. In addition his IFS indicated he fed himself independently with a fork and spoon and drank with a single handled mug. C1's Individual Abuse Prevention Plan (IAPP) dated 2/01/21, indicated C1 could be abused by others bigger/stronger than himself and had inability to identify potentially dangerous situations, inability to deal with verbally/physically aggressive persons and was unlikely to report abuse to appropriate persons. C2's IFS dated 5/3/21, indicated she had profound intellectual disabilities, was legally blind and had generalized anxiety disorder. The IFS further indicated she was assist of one with transfers and independent to walk. C2's IAPP dated 11/04/20, indicated she had inability to identify potentially dangerous situations and verbal/physical abuse. In addition C2's IAPP indicated she would not be able to report or defend herself from maltreatment. A Common Entry Point Intake Form dated 4/27/21, at 12:45 p.m. indicated a hospice nurse knocked at front door on 4/27/21, around lunch time and got no answer, entered the home and heard care giver [DSP-A] say to [C1] "You are a FUCKER and "YOU ARE PISSING ME OFF, YOU NEED TO EAT". Hospice nurse observed C1 at the counter with DSP-A next to him while he ate. The group home nurse was made aware of the witnessed verbal abuse by the hospice nurse.	5 815		

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5 815	Continued From page 4 During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed of the incident that occurred on 4/27/21, by her supervisor and was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house. The HS stated she was off that day so she did not make a report to the state agency and was unsure who made the report. During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated that morning as he got up C1, who was assist of 2, DSP-A entered the room and put up his fist up to C1 and said, "you better get up or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated he told DSP-A, "Why did you have to say that to him?" and DSP-A glared at him and walked away. DSP-B then stated later that day, at lunch time, he observed DSP-A put his hands in the freezer and then cup his hands around C1's neck and C1 was upset by this and shook his head no and shrinking away from DSP-A. DSP-B stated in January 2021, he observed DSP-A put his hands in the snow and come in the house and put his hands on C1's neck and shoulders to wake him up while he was in his w/c, C1 was not happy, and shook and whimpered. DSP-A looked at DSP-B and laughed. DSP-B stated there was another incident in March 2021, where he observed DSP-A punch C1's teddy bear right in front of him and said this was how you got C1 to make his bed. C1 was upset and said "No! No!" and shook his head and made his bed. DSP-B stated he was afraid to report things because DSP-A told DSP-B if he reported, things would	5 815		

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5 815	Continued From page 5 happened to him. DSP-B felt bullied and threatened by DSP-A. During an interview on 4/30/21, at 12:52 p.m. the company's internal investigator stated he completed the facility investigations of incidents that occurred. Through the course of the investigation of the verbal abuse on 4/27/21, he found out there were other incidents and staff who were bullied by DSP-A and did not report incidents and should have immediately informed management so a report could be made to the state agency. During an interview on 4/30/21, at 1:04 p.m., DSP-C stated she observed DSP-A verbally abuse C2 twice. DSP-C stated C2 was blind and assist of one but could hear and understand. DSP-C stated the first incident occurred in February 2021 while DSP-A got C2 up he said "get the fuck up" and the second one was in March 2021 when DSP-C overheard DSP-A say, "you fucking little bitch". DSP-C did not report either one of the incidents because DSP-A said, "Oh just go tell your mommy about this". DSP-C then stated her mother was the HS and felt she tried to deal with it on her own and told DSP-A to stop. She stated she was unaware of the ability to make a report to the SA directly. During an interview on 5/3/21, at 10:00 a.m. licensed practical nurse (LPN)-A stated she was informed by the hospice nurse of the incident with DSP-A and C1 on 4/27/21, and usually did not receive the calls about any incidents and did not make a report to the state agency and did not know she needed to. During an interview on 5/3/21, at 12:00 p.m. residential administrator stated these incidents	5 815		

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	01614	A. BUILDING: _____ B. WING _____	C 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTAI TRILLIUM	306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395

(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
5 815	Continued From page 6 should have been reported to the stated agency immediately by the facility. A Vulnerable Adults Maltreatment Reporting and Internal Review Policy reviewed 8/2018, indicated it was the policy of Mary T. Inc to protect the adults served by this program who are considered vulnerable to maltreatment and to require the reporting of suspected maltreatment. In addition the report indicated you must report immediately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 815		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email on May 19, 2021

Administrator
Mtai Trillium
306 Westgate Drive, Po Box 246
Winsted, MN 55395

RE: Event ID: X0UR11

Dear Administrator:

On May 4, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. This survey found one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the survey we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the electronically delivered "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy effective May 3, 2021.

One or more of these deficiencies do not meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID):

W122 42 CFR § 483.420 Client Protections

Federal certification deficiencies are delineated on the enclosed form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC).

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correctionk will be completed.

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" 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

Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by **June 28, 2021**, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed on May 19, 2021

Administrator
Mtai Trillium
306 Westgate Drive, Po Box 246
Winsted, MN 55395

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: XOUR11

Dear Administrator:

The above facility was surveyed on April 29, 2021 through May 4, 2021 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The 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 Supervised Living Facilities.

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 and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule 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.

When all orders are corrected, the first page of the order form should be signed and returned 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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Sarah Grebenc. A written plan for correction of licensing orders is not required.

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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

W122 - Failed to protect

W127 - Rights - Failed to assure right to be free from PA/NA/SA/Psych Abuse or punishment

W149 - Failed to implement Abuse policies by reporting (not reporting)

W153 - Reporting Abuse/neglect

W369 - G-tube meds administered together w/o an order to do so.