



Minnesota Department of Health

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Lake Owasso Residence			Report Number: HG208024 and HG208025	Date of Visit: September 7, 8, and 9, 2016
Facility Address: 210 Owasso Boulevard North			Time of Visit: 4:20 p.m. to 6:30 p.m. 7:00 a.m. to 5:30 p.m. 7:30 a.m. to 10:30 a.m.	Date Concluded: February 3, 2017
Facility City: Shoreview			Investigator's Name and Title: Jane Aandal, R.N., Special Investigator	
State: Minnesota	ZIP: 55126	County: Ramsey		

ICF/IID

Allegation(s):

It is alleged that facility staff failed to provide adequate supervision and two clients engaged in sexual activity with each other.

- Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when the facility failed to provide adequate supervision of two clients resulting in Client #1 forcing sexual activity with Client #2.

Client #1 was diagnosed with mild intellectual disability. Client #2 was diagnosed with moderate intellectual disability.

The two clients lived in adjacent areas on the same hallway. Client #1 resided at the facility for five days when staff notified the supervisor that there were concerns about the interactions between the two clients that put Client #2 at risk. Client #1 would follow Client #2 around and sit very close to Client #2. The supervisor told the staff member to keep eye contact on Client #1 and maintain separation between the two clients. The information was not shared with all staff members. No plan was implemented to provide additional supervision or other strategies to maintain the safety of all the clients.

Two days later, Client #2 told staff that Client #1 knocked on Client #2's door and asked for sex. Staff immediately reported this information to a supervisor. No additional supervision was implemented. Three days later, Client #1 was not in the common area and a staff person called out Client #1's name. Client #1 responded from Client #2's bedroom. Client #1 came out of the bedroom adjusting her/his pants. That same day, Client #2 told staff the two clients had sexual intercourse. The supervisor was notified, but no

additional supervision or interventions were implemented. The following day, Client #2 told another staff member that Client #1 raped Client #2. The supervisor notified the director who initiated an investigation. Client #2 was sent to the hospital for an evaluation and Client #1 was sent to the hospital because he was a danger to other clients.

Client #1 was interviewed and said Client #1 and Client #2 had sexual intercourse.

Client #2 was interviewed and said on three occasions, including the incident when Client #1 was in client #2's room, Client #1 had forced Client #2 to have sexual intercourse. Client #2 said s/he was too scared to tell anyone.

Client #2's hospital record was reviewed and the sexual assault exam indicated there was evidence of vaginal penetration and the client had a genital tear/laceration. During an interview, the sexual assault nurse examiner stated that Client #2's injury was consistent with vaginal penetration.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

- Abuse
- Neglect
- Financial Exploitation
- Substantiated
- Not Substantiated
- Inconclusive based on the following information:

Mitigating Factors:

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

Abuse Neglect Financial Exploitation. This determination was based on the following: The facility failed to provide adequate staffing levels in order to provide adequate supervision. The facility failed to increase client supervision after episodes of client to client sexual advances, which staff found concerning.

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

Compliance:

Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) - Compliance Not Met
The requirements under Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) were not met.

Deficiencies are issued on form 2567: Yes No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Supervised Living Facility (MN Rules Chapter 4665) - Compliance Not Met

The requirements under State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665) were not met.

State licensing orders were issued: Yes No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met

The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: Yes No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met

The requirements under State Statutes for Chapters 144 & 144A were not met.

State licensing orders were issued: Yes No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

When the facilities program director was notified of the allegation, contact was made with the county sheriff's office. Client #1 was transferred to a hospital for an evaluation as a danger to others and Client #2 was evaluated in the emergency room. During the month of September 2016, all treatment plans and behavior plans were reviewed and found to be up-to-date. However, the facility determined the supervisor guidelines were not being followed and subsequently there was a failure to report the allegation of maltreatment. Two supervisory staff were removed from delegated authority and are no longer responsible for making determinations of maltreatment and were reeducated to follow the Vulnerable Adult Policy to report concerns immediately to the administrator. Staff supervision guidelines were reviewed and all staff were educated on supervision and reporting of incidents. Policies and procedures were reviewed to ensure they are clear and understandable. The staffing levels were reviewed and were determined by the facility to be out of compliance with the abuse prevention plans and the facility staff received training on the staffing ratios.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including

but not limited to, food, clothing, shelter, health care, or supervision which is:

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

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

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

- Medical Records
- Nurses Notes
- Assessments
- Facility Incident Reports

Other pertinent medical records:

- Hospital Records
- Other, specify:

Additional facility records:

- Staff Time Sheets, Schedules, etc.
- Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

Were residents selected based on the allegation(s)? Yes No N/A

Specify: _____

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

Facility Name: Lake Owasso Residence

Report Number: HG208024 and HG208025

Yes No N/A

Specify: Client #1 was at the hospital and client #2 was at the facility

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) Yes No N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

Interview with family: Yes No N/A Specify: Client #1's guardian was interviewed

Did you interview the resident(s) identified in allegation:

Yes No N/A Specify: _____

Did you interview additional residents? Yes No

Total number of resident interviews: Two

Interview with staff: Yes No N/A Specify: _____

Tennessee Warnings

Tennessee Warning given as required: Yes No

Total number of staff interviews: 15

Physician Interviewed: Yes No

Nurse Practitioner Interviewed: Yes No

Physician Assistant Interviewed: Yes No

Interview with Alleged Perpetrator(s): Yes No N/A Specify: Not Identified

Attempts to contact:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

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

Were contacts made with any of the following:

Emergency Personnel Police Officers Medical Examiner Other: Specify _____

Observations were conducted related to:

Nursing Services

Was any involved equipment inspected: Yes No N/A

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

Facility Name: Lake Owasso Residence

Report Number: HG208024 and HG208025

Were photographs taken: Yes No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

The Office of Ombudsman for Mental Health and Developmental Disabilities

Ramsey County Attorney

Ramsey County Sheriff

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126	
(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 000	INITIAL COMMENTS	W 000		
W 200	<p>A complaint investigation was conducted to investigate case #HG208024 and #HG208025. As a result, the following deficiencies are issued.</p> <p>483.440(b)(3) ADMISSIONS, TRANSFERS, DISCHARGE</p> <p>A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.</p> <p>This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to review the preadmission documentation to assess the needs for 1 of 1 client (C1) reviewed when C1 had a history of predatory behavior.</p> <p>Findings include:</p> <p>The facility's admission and demission policy dated 2/2/16, indicated clients that may be too dangerous for continued placement would include repeated offenses, weapons, predatory behavior, stalking and serious injury to others.</p> <p>C1's record included documentation provided by C1's guardian prior to admission to the facility. The documents included information that C1 was discharged from a previous facility and admitted to a crisis facility for behavior management around 10/2015. C1 had a history of sexual</p>	W 200		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/27/2016
NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(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 200	<p>Continued From page 1</p> <p>aggression and would occasionally masturbate in common areas. C1 had several incidents of sexually inappropriate behavior with females in the past dating back to 2006 and 2009. Because of C1's past sexual history C1 was always to be supervised.</p> <p>C1's record included hospital nursing notes dated 7/20/16, at 10:00 p.m. which indicated C1 was at the end of the hallway with a female peer. The female peer reported C1 touched her inappropriately and asked her to have sex with him several times. The female peer told C1 she did not want him to touch her. C1 denied touching or making sexual comments to the female peer.</p> <p>C1's medical record was reviewed. C1's profile indicated C1 was admitted to the facility on 8/24/16, diagnosed with mild intellectual disability, Fetal Alcohol Syndrome and adjustment disorder.</p> <p>C1's morning progress note dated 9/3/16, documented by residential counselor (RC)-H indicated staff saw C1 in C2's room. C1 and C2 came out of the room together and RC-H asked C1 what he was doing. C1 denied any wrongdoing and RC-H saw C1 adjusting his pants, trying to hide his (missing a word), C2 came out of her room and went to the bathroom to wash herself up.</p> <p>C2's medical record was reviewed. C2's profile indicated C2 was diagnosed with moderate intellectual disability and had co-guardians.</p> <p>C2's individual abuse prevention plan dated 1/7/16, indicated C2 was not considered a consenting participant so decisions would be made by the guardian.</p>	W 200			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/27/2016
NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(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 200	<p>Continued From page 2</p> <p>C2's individual program plan dated 1/21/16, addressed C2's sexuality. C2 had been known to express feelings of affection for specific staff and peers and on occasion her teasing may become sexually suggestive. In the past, C2 may have been sexually involved with male peers, but these relationships occurred on her terms. C2 showed some ability to make acceptable choices regarding relationships, she would not be considered able to give informed consent for a sexual relationship. C2 was independent with toileting.</p> <p>C2's individual service plan dated 1/21/16, indicated C2 required 24-hour level of supervision which would include awake night staff. C2 had an intellectual age of 5 years and nine months. C2 could communicate her needs verbally.</p> <p>C2's evening progress note dated 9/3/16, documented by RC-D, indicated C2 reported to her that earlier in the day, C1 had entered her room and tried to "stick it in me." C2 stated she was fearful of saying no to C1 in case he would physically harm her. C2 was taught to report any verbal, physical, or sexual misconduct to staff immediately. C2 also reported this information to behavioral analyst-O and licensed practical nurse (LPN)-L.</p> <p>The nurse practitioner note dated 9/6/16, indicated the sexual assault nurse examined C2 on 9/4/16, and identified the following information. There was some evidence of penetration, the external genitalia had a tear 5 millimeters (mm) by 1 mm at 6 O'clock that was painful to touch, with C2 stating "OW" that hurts.</p>	W 200			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/27/2016
NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(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 200	<p>Continued From page 3</p> <p>C1 was interviewed on 9/8/16, at 10:26 a.m. C1 stated on 9/3/16, he had sexually penetrated C2 in her room. C1 stated C2 asked him to pull his pants down and have sex with her. C1 stated C2 touched his penis and it went inside of C2. C1 stated he would like to be placed in a group home with all male peers. In addition, C1 stated the staff were not watching and following him well enough. C1 stated on 8/30/16, C2 had him feel her breasts (unknown time).</p> <p>C2 was interviewed on 9/8/16, at 2:04 p.m. C2 stated on 9/3/16, C1 came to her room, pulled her pants down and put his "thing" in her vagina. C2 stated C1 kept asking her, previous to the incident, to come into her room and she did not want him in there. C2 stated C1 forced her to have sex with him that included penetration. C2 stated there had been two previous incidents when C1 came into her room and put his penis in her. C2 stated she was unable to scream because C1 was on her chest. C2 stated she was afraid to tell staff about the other two times because she thought she would get in trouble and felt staff would not believe her. C2 stated the previous two incidents had occurred prior to the evening meal (dates unknown).</p> <p>The program director was interviewed on 9/22/16, at 10:08 a.m. The program director stated when C1 was being considered for admission to the facility, she asked C1's guardian if C1 had a history of fire setting, a severe injury to a staff person, or wanting sexual activity from another client and was told "no" to all three questions. The program director stated C1 would not be a safe client for their population if he was wanting sex from another client and she did not feel C1 was a</p>	W 200			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/27/2016
NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(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 200	Continued From page 4 sexual threat to clients. The program director stated C1 was accepted for admission on 8/9/16, and arrived on 8/24/16. The program director was interviewed on 9/26/16, at 11:52 a.m. The program director stated she received email documentation from C1's guardian on 8/8/16, which included C1's hospital nursing notes dated 7/20/16, at 10:00 p.m. The program director stated she had not read the nursing note prior to accepting C1 for placement on 8/9/16.	W 200			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
5 000	<p>Initial Comments</p> <p>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.</p> <p>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.</p> <p>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. A complaint investigation was conducted to investigate case #HG208024 and #HG208025. As a result, the following correction orders are issued.</p>	5 000	<p>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.</p> <p>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</p>	

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
5 000	Continued From page 1	5 000	<p>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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by."</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	
5 700	<p>MN Statute 144.651 Subd. 14. RES. RIGHTS Freedom from maltreatment.</p> <p>Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.</p>	5 700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
5 700	<p>Continued From page 2</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident (R2) was free from maltreatment including resident to resident sexual abuse perpetrated by another resident (R1) when the facility did not provide adequate supervision.</p> <p>Findings include:</p> <p>Review of the facility's house three prevention plan revised 7/6/15, indicated the staffing pattern would be a one to four staff to resident ratio to ensure safety of all residents. The facility can pull staff as needed from any of the eight houses to ensure sufficient staffing was available for extraordinary circumstances.</p> <p>R1's record included documentation provided by R1's guardian prior to admission to the facility. The documents included information that R1 was discharged from a previous facility and admitted to a crisis facility for behavior management around 10/2015. R1 had a history of sexual aggression and would occasionally masturbate in common areas. R1 had several incidents of sexually inappropriate behavior with females in the past dating back to 2006 and 2009. Because of R1's past sexual history R1 was always to be supervised.</p> <p>The facility's Vulnerable Adult (VA) policy dated 2/2/16, indicated residents would be protected from maltreatment which includes abuse, neglect and financial exploitation. It was the responsibility</p>	5 700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/27/2016
NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(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
5 700	<p>Continued From page 3</p> <p>of the staff to assess, plan and implement practices that would keep residents safe from maltreatment.</p> <p>R1's hospital nursing notes dated 7/20/16, at 10:00 p.m. indicated R1 was at the end of the hallway with a female peer. The female peer reported R1 touched her inappropriately and asked her to have sex with him several times. The female peer told R1 she did not want him to touch her. R1 denied touching or making sexual comments to the female peer.</p> <p>R1's medical record was reviewed. R1's profile indicated R1 was admitted to the facility on 8/24/16, diagnosed with mild intellectual disability, Fetal Alcohol Syndrome and adjustment disorder.</p> <p>R1's morning progress note dated 9/3/16, documented by residential counselor (RC)-H indicated staff saw R1 in R2's room. R1 and R2 came out of the room together and RC-H asked R1 what he was doing. R1 denied any wrongdoing and RC-H saw R1 adjusting his pants, trying to hide his (missing a word), R2 came out of her room and went to the bathroom to wash herself up.</p> <p>R2's medical record was reviewed. R2's profile indicated R2 was diagnosed with moderate intellectual disability and had co-guardians.</p> <p>R2's individual abuse prevention plan dated 1/7/16, indicated R2 was not considered a consenting participant so decisions would be made by the guardian.</p> <p>R2's individual program plan dated 1/21/16, addressed R2's sexuality. R2 had been known to express feelings of affection for specific staff and</p>	5 700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
5 700	<p>Continued From page 4</p> <p>peers and on occasion her teasing may become sexually suggestive. In the past, R2 may have been sexually involved with male peers, but these relationships occurred on her terms. R2 showed some ability to make acceptable choices regarding relationships, she would not be considered able to give informed consent for a sexual relationship. R2 was independent with toileting.</p> <p>R2's individual service plan dated 1/21/16, indicated R2 required 24-hour level of supervision which would include awake night staff. R2 had an intellectual age of 5 years and nine months. R2 could communicate her needs verbally.</p> <p>R2's evening progress note dated 9/3/16, documented by RC-D, indicated R2 reported to her that earlier in the day, R1 had entered her room and tried to "stick it in me." R2 stated she was fearful of saying no to R1 in case he would physically harm her. R2 was taught to report any verbal, physical, or sexual misconduct to staff immediately. R2 also reported this information to behavioral analyst-O and licensed practical nurse (LPN)-L.</p> <p>RC-D was interviewed on 9/8/16, at 7:48 a.m. RC-D stated on 8/31/16, at 2:00 p.m. R2 was walking outside and reported to her that R1 had been knocking on her door asking for sex. RC-D stated she reported this to behavioral analyst-O and the program director and did not document R2's concern in her progress notes. RC-D stated on 9/3/16, at approximately 2:00 p.m. RC-N told her he had found R1 with R2 in her room that morning. RC-D stated she thought something sexual may have occurred between R1 and R2 based on the information R2 told her on 8/31/16. RC-D stated she then spoke with r2 who reported</p>	5 700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
5 700	<p>Continued From page 5</p> <p>that R1 had asked to come in her room and he "tried to stick it in me." RC-D stated she called licensed practical nurse (LPN)-L who came and spoke with r2.</p> <p>R1 was interviewed on 9/8/16, at 10:26 a.m. R1 stated on 9/3/16, he had sexual penetration with R2 in her room. R1 stated R2 asked him to pull his pants down and have sex with her. R1 stated R2 touched his penis and it went inside of R2. R1 stated he would like to be placed in a group home with all male peers. In addition, r1 stated the staff were not watching and following him well enough. R1 stated on 8/30/16, R2 had him feel her breasts (unknown time).</p> <p>RC-H was interviewed on 9/8/16, at 12:06 p.m. RC-H stated on 9/3/16, between 10:35 a.m. and 10:50 a.m. a male client asked him where R1 was and RC-H called out R1's name. R1 then answered and came out of R2's bedroom adjusting his pants. R1 denied that anything had happened. RC-H observed through R1's pants that R1 had an erection. RC-H called program supervisor-I and told him about the incident. Program supervisor-I directed RC-H to document the incident in the log book and not to fill out an incident report. RC-H stated about an hour later program supervisor-I came to the house and interviewed R1. RC-H stated program supervisor-I did not give any direction for any additional interventions.</p> <p>R2 was interviewed on 9/8/16, at 2:04 p.m. R2 stated on 9/3/16, R1 came to her room, pulled her pants down and put his "thing" in her vagina. R2 stated R1 kept asking her, previous to the incident, to come into her room and she did not want him in there. R2 stated R1 forced her to have sexual with penetration with him. R2 stated</p>	5 700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
5 700	<p>Continued From page 6</p> <p>there had been two previous incidents when R1 came into her room and put his penis in her. R2 stated she was unable to scream because R1 was on her chest. R2 stated she was afraid to tell staff about the other two times because she thought she would get in trouble and felt staff would not believe her. R2 stated the previous two incidents had occurred prior to the evening meal (dates unknown).</p> <p>The program director was interviewed on 9/9/16, at 9:54 a.m. The program director stated she did not feel staff received enough training related to R1. The program director stated the staff were to receive one on one training from the house supervisor and should have signed off that they had received r1's information. The program director stated there was no documentation the staff received training and she felt the facility was lacking policies to address the admission process.</p> <p>Program supervisor-I was interviewed on 9/10/16, at 7:55 a.m. Program supervisor-I stated on 9/3/16, after the two male clients left for the outing, he did not realize that RC-H was left at the house with five clients. Program supervisor-I stated the staffing level for the house should be one staff to four clients and verified the staffing level was actually one staff to five residents that morning. Program supervisor-I stated he had received a phone call from RC-H and was told R1 knocked on R2's door and found R1 in the room and he was adjusting his pants. Program supervisor-I stated he had no reason to believe that anything had happened between R1 and R2. Program supervisor-I stated behavioral analyst-O came to work on 9/3/16, at 2:00 p.m. and informed program supervisor-I that R2 had stated R1 had pulled down R2's pants and they had sex.</p>	5 700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
--------------------	--	---------------	---	--------------------

5 700	<p>Continued From page 7</p> <p>Program supervisor-I stated he felt the information was serious, however; he did not feel comfortable interviewing R2 and felt R2 would be more comfortable talking to a female. Program supervisor-I stated he felt R2 would be safe with the staff working the evening shift. Program supervisor-I stated he did not know if R2 knew what sex was and did not know if she was a credible reporter. Program supervisor-I stated he was not ready to call it sexual abuse and was not aware that any medical procedures needed to be done with R2. Program supervisor-I stated on 9/4/16, he arrived at 9:00 a.m. and behavioral analyst-O came in early to take clients to the Twins game. Program supervisor-I stated R2 and two male clients left for the noon game. Program supervisor-I stated he received a call from behavioral analyst-O about 12:15 p.m. and reported R2 said she was "raped" by R1 three times. Program supervisor-I stated this was a "game changer" and he called the program director who led the investigation. Program supervisor-I stated he did not want to accuse R1 of doing something he had not done.</p> <p>RC-N was interviewed on 9/12/16, at 10:07 a.m. RC-N stated prior to R1's admission there was no formal training provided and staff were to read R1's packet of information on their own. RC-N stated more training needed to be provided along with resident's supervision needs.</p> <p>The house supervisor was interviewed on 9/12/16, at 3:30 p.m. and stated prior to 9/3/16, he was not aware R1 had done anything inappropriate.</p> <p>Behavioral analyst-O was interviewed on 9/12/16, at 4:04 p.m. Behavioral analyst-O stated R1's informational packet was left in the house on</p>	5 700		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
--------------------	--	---------------	---	--------------------

5 700	<p>Continued From page 8</p> <p>8/19/16, for staff to read. Behavioral analyst-O stated a couple of days after admission R1 was observed following R2 around and would sit close to her on the love seat. Behavioral analyst-O stated he reported this to the program director and the house supervisor on 8/29/16, and told them he thought R1 was targeting R2. Behavioral analyst-O stated the guidance he received was to keep eye contact on R1. However, this information was not relayed to all staff members. Behavioral analyst-O stated he was frustrated how the incident was handled.</p> <p>RC-Q was interviewed on 9/15/16, at 8:02 p.m. RC-Q worked the night shift and stated he read the packet of information on R1 and felt staff did not have the knowledge and training they needed to care for R1.</p> <p>RC-R was interviewed on 9/20/16, at 12:39 p.m. RC-R worked the night shift on 9/3/16, and stated there was no directive from a supervisor as to how often R1 should be supervised. RC-R stated RC-D suggested to keep the lights on in the hallway and observe. RC-R stated he was surprised R1 was still residing next door to R2.</p> <p>The program director was interviewed on 9/22/16, at 10:08 a.m. She stated when R1 was being considered for admission to the facility, she asked R1's guardian if R1 had a history of fire setting, a severe injury to a staff person, or wanting sexual activity from another client and was told "no" to all three questions. The program director stated R1 would not be a safe client for their population if he was wanting sex from another peer and she did not feel R1 was a sexual threat to clients. The program director stated R1 was accepted for admission on 8/9/16, and arrived on 8/24/16. The program director</p>	5 700		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
5 700	<p>Continued From page 9</p> <p>stated RC-D had told her prior to 9/3/16, that R1 and R2 were getting friendly and their legs were touching at the dinner table and that R1 was asking R2 for sex. Behavioral Analyst-O directed that R1 and R2 be moved to different places at the table. The program director stated she talked with the house supervisor about the information and assumed he would assess and supervise the situation with R1 and R2. The program director stated the house supervisor told her R1 was being redirected away from R2's room. The program director stated on 9/4/16, at 1:09 p.m. she received a phone call from program supervisor-I who said there was sexual contact between R1 and R2, which may have involved intercourse. The program director stated she arrived at the facility at 2:15 p.m. on 9/4/16, and interviewed R1 who admitted he had sex with penetration with R2. The program director stated it was not acceptable to have a one to five staff to client ratio on 9/3/16. The program director stated R2 would keep her door locked and had a key for her room. The program director stated program supervisor-I did not think R1 coming out of R2's room on 9/3/16, as an incident. The program director stated it was an incident and a report should have been filled out, the administrator notified, the state agency notified, an investigation started, R1 removed from the campus and R2 examined in the emergency department. The program director stated it was a poor decision not to have R2 seen in the emergency department on 9/3/16, and the facility lacked policies to address this kind of situation with procedures.</p> <p>The administrator was interviewed on 9/22/16, at 2:06 p.m. The administrator stated on 8/31/16, there was a leadership meeting, and she was informed R1 had been masturbating and knocking on R2's door. The administrator stated</p>	5 700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
--------------------	--	---------------	---	--------------------

5 700	<p>Continued From page 10</p> <p>this was discussed with the house supervisor and he was to address the situation with the staff and find out what was going on.</p> <p>LPN-L was interviewed on 9/22/16, at 4:33 p.m. LPN-L stated on 9/3/16, at 2:35 p.m. she received a call from RC-D. RC-D wanted LPN-L to talk with R2. LPN-L stated R2 was agitated so she came back between 3:30-4:00 p.m. and talked with R2 in her room. R2 pointed to her vaginal area and stated it hurt down there. R2 told LPN-L that R1 had his pants down and entered her. R2 was upset and crying. LPN-L asked r2 if she wanted to go and see someone and she became more agitated. LPN-L stated she was going to have R2 see the nurse practitioner on 9/6/16, when she was on campus. LPN-L stated she reported what R2 said to program supervisor-I and stated she felt R2 was telling the truth. LPN-L stated she thought program supervisor-I would handle the situation. LPN-L stated program supervisor-I was trying to figure out what to do. LPN-L stated she was not aware of any sexual abuse policy and what to do when it occurred with a client. LPN-L stated this was the first time she had dealt with nonconsensual sex. LPN-L stated she was dealing with other medical issues that day and felt staff from the day shift should have filled out an incident report. LPN-L stated on 9/4/16, R2 was seen in the emergency department.</p> <p>The nurse practitioner note dated 9/6/16, indicated the sexual assault nurse examined R2 on 9/4/16, and identified the following information. There was some evidence of penetration, the external genitalia had a tear 5 millimeters (mm) by 1 mm at 6 O'clock that was painful to touch, with R2 stating "OW" that hurts.</p> <p>The program director was interviewed on 9/26/16,</p>	5 700		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(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
5 700	Continued From page 11 at 11:52 a.m. The program director stated she received email documentation from R1's guardian on 8/8/16, which included R1's hospital nursing notes dated 7/20/16, at 10:00 p.m. The documentation indicated R1 was at the end of the hallway with a female peer. The female peer reported R1 touched her inappropriately and asked her to have sex with him several times. The female peer told R1 she did not want him to touch her. R1 denied touching or making sexual comments to the female peer. However, the program director stated she had not read the nursing note prior to accepting R1 for placement on 8/9/16. Time Period for Correction: Twenty-one (21) days.	5 700		
5 895	MN Statute 626.557 Subd. 14. VA Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other	5 895		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
5 895	<p>Continued From page 12</p> <p>individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and</p> <p>(3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.</p> <p>(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure individual abuse prevention plans were completed timely for 2 of 2 newly admitted residents (R1, R5) who were reviewed for individual abuse prevention plans.</p> <p>Findings include:</p> <p>Review of the facility's policy on Vulnerable Adult (VA), dated 2/2/16, indicated upon intake the facility would develop an individual abuse prevention plan that would contain an</p>	5 895		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
5 895	<p>Continued From page 13</p> <p>assessment of each client's susceptibility to abuse and specific measure to be taken to minimize the risk of maltreatment. The assessment was to be reviewed annually. However, the current policy did not address the client's risk for abusing other vulnerable adults.</p> <p>R1's medical record was reviewed. R1's profile indicated R1 was admitted to the facility on 8/24/16, diagnosed with mild intellectual disability, Fetal Alcohol Syndrome and adjustment disorder.</p> <p>R5's medical record was reviewed. R5's individual program plan dated 6/7/16, indicated R5 was admitted on 4/25/16, diagnosed with intellectual disability and autism.</p> <p>The program director was interviewed on 9/8/16, at 3:54 p.m. The program director stated the facility practice has been to complete assessment within 30 days of admission. The program director stated they had been using the intake packet of information as the vulnerability assessment versus completing their own. The program director stated R1 did not have a vulnerability assessment completed to identify his risk of abusing other vulnerable people. The program director stated R5 was admitted on 4/25/16, however; R5's vulnerability assessment was not completed until 6/7/16. The program director stated they were not following their VA policy and completing the assessment upon intake of the client to the facility. The program director stated they needed to update their VA policy and change their current practice.</p> <p>The program director was interviewed on 9/22/16, at 10:08 a.m. The program director stated R1 was accepted for admission on 8/9/16.</p>	5 895		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
--	---

(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
5 895	Continued From page 14 Time Period for Correction: Twenty-one (21) days.	5 895		



Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

April 11, 2017

Ms. Dana Castonguay, Administrator
Lake Owasso Residence
210 Owasso Blvd North
Shoreview, MN 55126

RE: Project Number HG208024 & HG208025

Dear Ms. Castonguay:

On March 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to two abbreviated standard surveys, numbered HG208024 & HG208025 completed on December 27, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our survey, completed on December 27, 2016.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

A handwritten signature in black ink that reads 'Kate Johnston'.

Kate Johnston, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File



Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6818
April 11, 2017

Ms. Dana Castonguay, Administrator
Lake Owasso Residence
210 Owasso Boulevard North
Shoreview, MN 55126

Re: Enclosed Re-inspection Results - Project Number HG208024 & HG208025

Dear Ms. Castonguay:

On March 24, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a re-inspection of your facility, to determine correction of orders found on the survey completed on December 27, 2017 with orders received by you on January 17, 2017. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

A handwritten signature in black ink that reads 'Kate Johnston'.

Kate Johnston, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File