DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed 03/31/2020

March 31, 2020

Administrator
Lake Owasso Residence
210 Owasso Blvd North
Shoreview, MN 55126

RE: Project Number HG208066C

Dear Administrator:

During this period of pandemic COVID-19 outbreak, State Agencies (MDH) are changing the process for survey prioritization and enforcement remedies. MDH is delaying revisit surveys and are exercising enforcement discretion during this prioritization period, beginning March 23, 2020. As a result, the below enforcement actions resulting from this survey cycle will be suspended until revisits are again authorized.

This letter also requests that your facility submit a plan of correction. Although revisit surveys will not be conducted during the prioritization period, you may still submit your facility's POC during this time and the case will be held. Your facility may delay submission of a POC until the prioritization period is over.

On March 5, 2020, a complaint investigation was conducted at Lake Owasso Residence by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the Conditions of Participation (COP).

The following complaint HG208066C was found to be substantiated, with deficiencies.

At the time of the complaint investigation the survey team noted 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 complaint invesitgation 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 enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy on March 5, 2020.

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): This is listed below.

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). Ordinarily, a provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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:

Karen Aldinger, RN
HFE-Unit Supervisor, Metro Team A
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
Office: 651-201-3794 | Mobile: 320-249-2805

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 April 19, 2020, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

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

Sincerely,

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 31, 2020

Administrator
Lake Owasso Residence
210 Owasso Blvd North
Shoreview, MN 55126

Re: Project Number HG208066C

Dear Administrator:

On 3/4/20 through 3/5/20 a complaint investigation was conducted to investigate HG208066C. The complaint was found to be SUBSTANTIATED. No licensing orders were issued. Your facility is in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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,

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00831	A. BUILDING: _____ B. WING _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE OWASSO RESIDENCE	**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	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 3/4/20 through 3/5/20 a complaint investigation was conducted to investigate HG208066C. The complaint was found to be SUBSTANTIATED. No licensing orders were issued. Your facility is in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).	5 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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W 000	INITIAL COMMENTS On 3/4/2020 through 3/5/2020, an abbreviated survey was conducted to investigate HG208066C. Your facility was NOT IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. In addition The Conditions of Participation: Client Protection 42 CFR 483.420 found not met. An extended survey in the the area of client protection was conducted. HG208066C was substantiated with deficiencies issued at W122 and W127. An Immediate Jeopardy was identified at W122 and W127 on 2/27/20 at 3:30 p.m. The immediate jeopardy began on 12/23/20, when RC1-D was allowed to return to work with vulnerable clients after RC1-D was witnessed to hit P1 in the abdomen and head. The immediate jeopardy was removed on 3/5/20, 12:45 p.m. when the facility implemented measures to protect residents.	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	W 122		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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W 122	Continued From page 1 Client Protection, was not met. The facility failed to ensure client protections from abuse resulting in risk of abuse to all 59 clients, when Resident Counselor 1-D (RC 1-D) hit C1 in the abdomen and head, but was allowed to return to work with other vulnerable clients unsupervised. This resulted in an immediate jeopardy to client health and safety. The immediate jeopardy began on 2/25/20, when RC 1-D was allowed to return to work after RC 1-E was witnessed hitting C1 in the abdomen and head. The IJ was identified on 3/4/20. The Administrator was notified of the immediate jeopardy at 2:14 p.m. on 3/4/20. The immediate jeopardy was removed on 3/5/20, 12:45 p.m. when the facility implemented measures to protect residents. Findings include: See W127: The facility failed to ensure protection from abuse for 1 of 1 client (C1) and the other 59 clients who resided in the facility when RC 1-D physically abused C1 and the facility continued to allow RC 1-D to provide services to clients.	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	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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W 127	Continued From page 2 facility failed to ensure that all clients were protected from potential abuse when a staff member Resident Counselor 1 (RC1-D) was witnessed to hit 1 of 1 client (C1) in the abdomen and head. Facility staff allowed RC1-D to care for other clients in the other facility homes unsupervised, placing all 59 clients in the facility potentially at risk and resulting in an immediate jeopardy situation. The immediate jeopardy began on 2/25/20, when RC1-D was allowed to return to work after RC1-E was witnessed hitting C1 in the abdomen and head. The IJ was identified on 3/4/20. The Administrator was notified of the immediate jeopardy at 2:14 p.m. on 3/4/20. The immediate jeopardy was removed on 3/5/20, 12:45 p.m. when the facility implemented measures to protect residents. Findings include: Record review revealed C1 was admitted to the facility on 2/11/11. C1's diagnoses included Moderate Mental retardation, Autism and a history of a head injury. C1's abuse prevention plan, dated 2/14/19, revealed C1 was at risk for abuse, in part because he was unable to, "deal with verbally and physically aggressive persons." During an interview on 3/4/20, at 7:50 a.m. C1, who is mostly non-verbal, nodded yes someone hit him recently. When asked who C1 stated, [RC1-D's Name]." During an interview on 3/4/20, at 12:00 p.m. RC1-E stated she witnessed RC1-D hit C1 in the abdomen and in the face. She stated C1 had been in house 4 on 2/18/20, with her for the	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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W 127	Continued From page 3	W 127		

afternoon and through dinner. Prior to coming to house 4, he had been upset and sweating profusely. She was able to calm him. When she said it was time for him to go back to house 1, he did not want to go back. She brought him back to house-1 and she witnessed RC1-D say to C1 something like the following, "It is not over just because you left." Then C1 said, "No, [RC1-D], No." RC1-D put on black gloves saying, "You know what this means." RC1-D closed the blinds, and C1 started jumping. RC1-D said, "Don't worry I'm not going to hit you yet." Then RC1-D walked up to C1 and punched him in the abdomen. C1 then sat down and said, "OK, OK." RC1-D then said, "Do you want more?" C1 said "No, No." RC1-D walked away, C1 put up his middle finger, and RC1-D walked up to C1 and hit him across the head/face twice. C1 then said, "Call police, call my mom." C1 was using more words than he usually does, then he ran into his room. Two other staff saw the altercation and did nothing. RC1-E stated she then went to report the incident to her supervisors.

During an interview on 3/4/20, at 8:30 a.m. Program Director B (PD-B) stated when the allegation of RC1-D assaulting C1 was made, the facility placed RC1-D on leave to protect clients. When administrative staff interviewed the other staff who would have witnessed the incident, those staff stated they did not see an assault. The clients present stated they did see RC1-D hit C1. PD-B stated she thought the allegation was inconclusive and she had no evidence, so they facility brought RC1-D back to work in a different house from C1 on 3/25/20. Although staff retraining was provided, PD-B stated P1 was on the schedule to work with clients without increased supervision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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W 127	Continued From page 4 A review of staffing revealed RC1-D worked on 2/25/20- House 7, evening shift with 7 clients, 2/26/20 House 8, evening shift, with 8 clients, 2/29/20 and 2/30/20- House 3, evening shift with 8 clients, 3/3/20-House 4, evening shift, with 7 clients. A review of the policy titled Vulnerable Adults and Reporting of Incidents, dated 1/11/19, revealed the following: Under section J. Corrective Action Plan: 1. Based on the results of the internal review, the Administrator or designee must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by individuals of the program, if any, and ensure the health and safety of the vulnerable adult. The immediate jeopardy was removed on 3/5/20, 12:45 p.m. when the facility implemented measures to protect residents by placing RC1-D on an indefinite administrative leave for the purpose of continuing the investigation into said allegations, to include external investigative decisions by law enforcement and count officials, revised policy/procedures and educated staff.	W 127		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
24G208	A. BUILDING _____ B. WING _____	3/5/20

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Owasso Residence	210 N. Owasso Blvd., Shoreview, MN 55126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility failed to ensure client protections from abuse resulting in risk of abuse to all 59 clients, when Resident Counselor 1-D (RC 1-D) hit C1 in the abdomen and head, but was allowed to return to work with other vulnerable clients unsupervised. This resulted in an immediate jeopardy to client health and safety approved 8/21/20 received 8/14/20	W122 W127	Based on the review of this area of concern, the following is the plan of correction: Mr. Dayee has been placed on administrative leave on 3/5/2020 and has not returned to the facility. If Mr. Dayee returns to the facility, he will placed on intense direct supervision by the program supervisors, operations director, and services director as needed. The Vulnerable Adult policy was updated to contain the following information on 3/5/2020 and assigned for staff training: An exception to an internal review will be made if any incident of alleged abuse/maltreatment is emergently referred to law enforcement as potential criminal conduct and the alleged perpetrator is taken into custody pending investigation. Under this circumstance, the facility will: i.Place the alleged perpetrator on paid leave for the time necessary to complete the law enforcement investigation and make a charging decision. ii.Refer the incident and the alleged perpetrator to the Ramsey County Office of Investigations for an external investigation of the incident rather than conducting an internal review. The alleged perpetrator will also remain out of the facility on paid leave until this investigation is complete. iii.The facility will act on the findings of the law enforcement investigation and that of the Ramsey County Office of Investigations and sanction the employee as warranted based on the outcomes. iv.The Administrator, Program Director or any designee will have authority to place an alleged perpetrator on paid leave immediately under this section. Complete by 4/5/2020	7/29/2020

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 reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	8/4/20

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email December 7, 2020

Administrator
Lake Owasso Residence
210 Owasso Blvd North
Shoreview, MN 55126

RE: Event ID: WXDS12

Dear Administator:

On November 3, 2020, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) 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. Based on the PCR complaint investigation, we have determined your facility does 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) and standard deficiencies pursuant to the complaint investigation, on March 5, 2020. The Condition of Participation that was corrected is listed below.

W122 42 CFR § 483.420 Client Protections

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

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

Sincerely,

Amy Johnson

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-201-9697

Enclosure

cc: Licensing and Certification File