

Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed August 26, 2020

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

RE: Event ID: 330Y11 Project Number: HG208080C,HG208082C, HG208083C

Dear Administrator:

On July 27, 28, 29, 2020, an abbreviated survey was conducted to investigate HG208080C, HG208082C and HG208083C. The facility was found NOT to be in compliance with the requirements of 42CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

In addition, The Condition of Participation: Client Protection 42 CFR 483.420 was found not met.

HG208080C, HG208082C and HG208083C were 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 August 7, 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.

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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:

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Susie Haben, Unit Supervisor St. Cloud A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 3333 West Division Street, Suite 212 St. Cloud, Minnesota 56301 Email: susie.haben@state.mn.us Phone: 320-223-7356 Fax: 320-223-7348

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 **September 27, 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,

Any Johour

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

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				`́сом	E SURVEY PLETED
		24G208	B. WING				C 07/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE OV	VASSO RESIDENCE				10 OWASSO BLVD NORTH HOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	rs	W 00	00			
	survey was conduc HG208080C, HG20 The facility was fou with the requiremen	08082C and HG208083C . nd NOT to be in compliance nts of 42CFR 483 Subpart I, are Facilities for Individuals					
		ndition of Participation: Client 483.420 was found not met.					
	were substantiated W122, W127.	08082C and HG208083C with deficiencies issued at esult of the investigations ed.					
		pardy (IJ) was identified at at 2:16 p.m. and removed n.					
	alleged perpetrator (RC)-Q was witness to be yelling, cuppir the client with a tow verified she had ob not reported it due to did not want to be a to remain anonymo (DO) was notified o p.m. The IJ was re a.m. when the facili to assess and ensu determined strategi incidents of abuse.	ppardy began on 7/18/20, when (AP) resident counselor sed by clients and staff person ng a client's face and hitting vel. When interviewed, RC-R served RC-Q's actions but had to fear of retaliation by RC-Q, a "whistle blower" and wanted bus. The director of operations of the IJ on 7/29/20, at 2:16 smoved on 8/7/20, at 11:45 ity had implemented measures are all clients safety, and ties to ensure staff would report					
W 122	CLIENT PROTECT	IONS	W 12	22			

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

TITLE

(X6) DATE

PRINTED: 08/26/2020

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 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.

	-	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	0	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	i			PLETED C
		24G208	B. WING					07/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE,	ZIP CODE		
LAKE OV	WASSO RESIDENCE				210 OWASSO BLVD NORTH SHOREVIEW, MN 55126			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
W 122	CFR(s): 483.420	sure that specific client	W 1	22				
	Based on interview Condition of Particip Client Protection wa to protect 4 of 4 clies	s not met as evidenced by: v and document review, the pation at 42 CFR 483.420 as not met. The facility failed ents (C7, C8, C9 and C10) vsical abuse, and failed to s for reporting and						
W 127	clients (C7,C8,C9 a PROTECTION OF CFR(s): 483.420(a) The facility must en Therefore, the facili	(5) sure the rights of all clients. ty must ensure that clients are ysical, verbal, sexual or	W 1	27				
	Based on interview facility failed to prot and C10) from phys member (talking rou the face and hitting facility failed to add	s not met as evidenced by: v and document review, the ect 4 of 4 clients (C7, C8, C9 sical/verbal abuse by a staff ugh, yelling, cupping a client in with a towel). In addition, the ress and implement strategies at the facility had knowledge						

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PRINTED: 08/26/2020

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G208	B. WING				C 07/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE OV	VASSO RESIDENCE				210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 127	required by law and in an immediate jeo safety of all 4 clients The Immediate Jeo alleged perpetrator (RC)-Q was witness to be yelling, cuppin the client with a tow verified she had obs not reported it due to did not want to be a to remain anonymo (DO) was notified o p.m. The IJ was re a.m. when the facilit to assess and ensu determined strategi incidents of abuse. Findings include: C7's Profile sheet u had profound intelle Abuse Prevention F indicated he was su likely to cooperate i inability to be assert unable to report inc C 8's Profile sheet u had mild intellectua disorder, adjustmer emotions and condu- disorder. IAPP date susceptible to abus potentially dangerou	ers refusing to report abuse as facility policy. This resulted pardy (IJ) to the health and s. pardy began on 7/18/20, when (AP) resident counselor sed by clients and staff person og a client's face and hitting rel. When interviewed, RC-R served RC-Q's actions but had to fear of retaliation by RC-Q, a "whistle blower" and wanted us. The director of operations f the IJ on 7/29/20, at 2:16 moved on 8/7/20, at 11:45 ty had implemented measures re all clients safety, and es to ensure staff would report pdated 7/27/20, indicated he ectual disability. C7's Individual Plan (IAPP) dated 4/16/20, isceptible to abuse, and is n an abusive situation and has tive. In addition he would be idents of abuse. updated 7/27/20, indicated he I disability, schizoaffective nt disorder with mixed uct, pervasive development ed 5/21/20, indicated C 8 was e, inability to identify us situations, may have	W	127			
	potentially dangerou						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE	0938-0391 SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP	
24G208 B. WING 08/0	; 7/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE OWASSO RESIDENCE       210 OWASSO BLVD NORTH         SHOREVIEW, MN 55126	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127       Continued From page 3 him vulnerable to abuse and an inability to deal with verbally/physically aggressive persons.       W 127         C 9's Profile sheet updated 7/27/20, indicated she had mild intellectual disability, schizoaffective disorder, post-traumatic stress disorder, personality disorder, anxiety and ADD (attention deficit disorder). C 9's IAPP dated 1/9/20, indicated she was susceptible to abuse, inability to identify potentially dangerous situations, may have inappropriate interactions with others which made her vulnerable to abuse and an inability to deal with verbally/physically aggressive persons.         C10's Profile sheet updated 7/27/20, indicated he had mild intellectual disability, generalized anxiety disorder with obsessive compulsive features and ADHD (attention deficit hyperactivity disorder). C10's IAPP dated 4/28/20, indicated he was susceptible to abuse, inability to identify potentially dangerous situations, may have inappropriate interactions with others which made him vulnerable to abuse and an inability to deal with verbally/physically aggressive persons.         A facility reported Common Entry Point (CEP) intake form dated 7/23/20, indicated two reports were made by C7's housemates (names not identified) indicating they hal witnessed RC-Q hit C7 with a bath towel and thought the actions caused C7 to become angry. Further, the report indicated RC-Q had hit C7 with the bath towel because C7 was trying to take RC-Q's cell phone or electronic tablet. The report indicated RC-Q would get frustrated with C7 easily and was always trying to take her stuff. The report also included, "Housemate reported they witnessed her cupping and slapping [C7's] face after he throws items, typically puzzle pieces or small	

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		AND HUMAN SERVICES				FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		24G208	B. WING				C 07/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	WASSO RESIDENCE				210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 127	items he finds on the that was described with both hands in the movie "Home Alone after shave on it, and hard." A facility CEP report had reported that of and yelled at her and works. The report of told C 9 to go to hell the supervisor on d bossing residents at she helped with me not let her, had told told her to get out of indicated C 9 felt she child. In addition, C was told by RC-Q to move out. The report RC-Q, did not want in her room crying, because she did not who made her feel reported she had w who was unable to [C7]. A facility reported C indicated C 8 report his house when RC- by RC-Q many time and does not want for indicated when RC- 7/18/20, C 8 had tri Operations and RC dude out." The report	ge 4 he floor. The type of slapping resembles cupping [C7's] face the same manner from the e" cups his face after putting hd slapping [C7's] face real t dated 7/23/20, indicated C 9 n 7/18/20, RC-Q was mean hd housemates a lot when she further indicated RC-Q had r room, didn't want C 9 to call uty that day, and was loud and round. C 9's report indicated eals everyday but RC-Q would her she would get hurt, and of the kitchen. The report he was being treated like a C 9 reported at one point she be either go to her room or ort indicated C 9 felt afraid of her to return, spent two hours and had "slept all day Sunday" of want to be around RC-Q bad about herself. C 9 also itnessed RC-Q hit a resident speak for himself with a towel EEP report dated 7/24/20, ted he feels uncomfortable in c-Q works and had been told es that she does not like him to talk to him. The CEP report -Q had worked the weekend of ed to talk to the Director of -Q had said, "Don't follow that ort indicated when [C 8] had the was doing, RC-Q had	W	127			

Facility ID: 00831

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		24G208	B. WING				C 07/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE O	WASSO RESIDENCE				210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 127	stated to C 8, "I'm of indicated C 8 stated and mean, saying s scheduled to work I weekend." The rep housemate had ask phone number, RC- told him to mind his During interview with Program Director (0 discussed his interview with RC-R had stated sh between RC-Q and she was in the laun During interview with a.m. C 9 stated on was yelling at every his chest multiple ti take her phone and got mad when RC-C hitting himself on th away. C 9 stated he also witnessed the did nothing to stop been going on for a and her housemate adding, "[RC-Q] res because she thinks C 9 also reported R several months ago to take her medicat not report this to an	In the facility's Operations OPD) on 7/27/20, at 9:42 a.m. view with RC-R (1 of 2 staff f alleged abuse) stating RC-R ot be a whistle blower" and ll on anyone. The OPD stated he may have heard yelling another client (C 9), but that	W -	127			

Facility ID: 00831

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G208	B. WING	i			C 07/2020
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE O	WASSO RESIDENCE				210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 127	p.m. C 8 reported th (7/18/20) was "the v stated RC-Q was "r and telling me that s C 8 stated he wishe C 8 also said he is a had not hit him befor the face several tim papers." C 8 also st because C7 was m stated RC-Q had ca treating him like this would go to another he had not reported Attempts were mad determined not to b RC-R was interview and stated she had 7/17/20, and heard the house, but did r blower." RC-R furth to the clients in Hou observed RC-Q cup RC-C stated she did to C7, but just wish with respect. Further afraid to report anyt environment at the she is a mandated due to her fear. RC-S stated during p.m. he worked the not work with RC-Q be intimidating and 1. Additionally, RC-	he last weekend RC-Q worked worst weekend ever." C 8 mean and rude, ignoring me she did not want to talk to me." ed RC-Q wanted to talk to him. afraid of RC-Q. C 8 said RC-Q ore, but "has slapped [C7] in the because [C7] was throwing tated RC-Q hit C7 with a towel essing with RC-Q's purse. C 8 alled him ugly and had been is for years so he wished RC-Q r house to work. C 8 confirmed at the abuse previously.	W	127			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G208	B. WING				C 07/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE O	WASSO RESIDENCE				10 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 127	During interview wit a.m. RC-Q stated, ' Saturday 7/18/20, a 7/19/20I was shoo me last Friday and a verbal abuse case, the DPO had told he but would get back would never do that hurt any of them. I he time. I was joking we taking pictures of me to quit my job, it jus [RC-R] lied and ma about me, I know it. want!" RC-Q then se contacting the union know, this could wro RC-Q further stated become a social wo worried about that the she talks loud but s clients or verbally a During interview 7/2 stated, "[RC-Q] is ru the f (profanity) ou I have to cover my of last weekend she we side of the face with sound, it was either saw her hit [C7] with On that weekend [C cabinet and [RC-Q] by herself, and pino	eagues on the campus." th RC-Q on 7/28/20, at 9:24 "I worked the evening shift on and a double on Sunday cked when the [DPO] called said I was suspended about a I was shocked." RC-Q stated er he could not tell her more to her soon. RC-Q stated, "I t to the clients. I would never have worked here for a long with them that day. [C 9] was ne outside. I think I am going t is not worth risking it. I bet de the clients make this up . [RC-R] gives them what they stated, "I guess I will be n and letting my other job eck my career you know!" d she was going to school to orker, "This is my passion, I'm oo." RC-Q stated she knows tated she does not yell at the	W 1	27			

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		AND HUMAN SERVICES				FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G208	B. WING				C 07/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
LAKE OV	WASSO RESIDENCE				10 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
				3			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 127	Continued From pa	ge 8	W 1	27			
		m Director (SPD) stated the					
		ained to their Vulnerable Adults					
		0 because they were aware of					
		aff being afraid of reporting due					
		eported in February 2020 er reported on another staff					
		ral of the staff then shunned					
		stated they were aware some					
		ot report due to fear of					
		cated 4 years ago the facility					
		e in to address cultural					
		unsuccessful. They also					
		een trying to get an additional PD and SPD identified they					
		ural backgrounds played a role					
		g staff and their willingness to					
		er. When asked if they had					
		ch as creative scheduling					
		nbers of same cultures were					
		er) to ensure clients were safe					
		e reported or Zero Tolerance orting were in place, etc. they					
		vide other action that had been					
	taken regarding sta						
	5 5	ľ					
		ed 7/13/20, Reporting of					
		Inerable Adults, indicated					
	under Procedure C						
		t to the appropriate authorities Minnesota Adult Abuse					
		MAARC) abuse including					
	1 0 (	, sexual, psychological,					
		nental harm, physical harm,					
	psychological harm	, or exploitation regardless of					
	who is the alleged p	perpetrator. The designee will					
		ator or administrator designee,					
		rviews, statements, physical					
		nent, maps, pictures or f all information related to the					

		AND HUMAN SERVICES				FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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LAKE O	WASSO RESIDENCE				10 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 127 W 154	allegation and provi action plan as imme Policy further indica mandated reporter believe a vulnerable to abuse, neglect, r injuries of unknown involuntary seclusic property who fails to serious or recurring employment in posi with persons receiv licensing by the De and by the Minnesco The Immediate Jec at 11:45 a.m. when from the schedule p an internal investiga of all clients to ensu and implemented s would report allega STAFF TREATMEN CFR(s): 483.420(d) The facility must haviolations are thoro This STANDARD is The facility failed to allegations of abuse and C10) who were physically abused b Findings include:	ide initial assessment and ediate corrective action. The ated: Failure to Report 1. A who knows or has reason to e adult is or has been subject maltreatment, mistreatment, a source, exploitation, on, and misappropriation of o report that is found to be g may be disqualified from itions allowing direct contact ving services from programs partment of Human Services ota Department of Health. opardy was removed on 8/7/20, the facility removed the AP pending investigation, began ation, conducted assessment ure safety, and had developed trategies to ensure their staff tions as required. NT OF CLIENTS )(3) ave evidence that all alleged ughly investigated.	W 1				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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	WASSO RESIDENCE				10 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 154	Abuse Prevention F indicated he was su likely to cooperate i inability to be asser unable to report inc C8's Profile sheet u had mild intellectua schizoaffective disc mixed emotions and development disord indicated C8 was su identify potentially of have inappropriate made him vulnerab with verbally/physic C9 Profile sheet up had mild intellectua disorder, post-traum personality disorder deficit disorder). C9 indicated she was so to identify potentiall have inappropriate made her vulnerabl with verbally/physic C10's Profile sheet had mild intellectua disorder with obses ADHD (attention de C10's IAPP dated 4 susceptible to abus potentially dangerou inappropriate intera him vulnerable to a	ectual disability. C7's Individual Plan (IAPP) dated 4/16/20, usceptible to abuse, and is n an abusive situation and has tive. In addition he would be	W	154			

If continuation sheet Page 11 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G208	B. WING	i			C 07/2020
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
LAKE OV	VASSO RESIDENCE				210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 154	Continued From pa	ge 11	W	154	4		
	intake form dated 7 were made by C7's identified) indicating C7 with a bath towe caused C7 to becor indicated RC-Q had because C7 was try or electronic tablet. would get frustrated always trying to take included, "Housema her cupping and sla throws items, typica items he finds on th that was described with both hands in t movie "Home Alone after shave on it, ar hard." A facility CEP repor had reported that of and yelled at her ar works. The report f told C9 to go to her the supervisor on d bossing residents a she helped with me not let her, had told told her to get out o indicated C9 felt sh- child. In addition, C was told by RC-Q to	common Entry Point (CEP) /23/20, indicated two reports housemates (names not g they had witnessed RC-Q hit el and thought the actions me angry. Further, the report d hit C7 with the bath towel ving to take RC-Q's cell phone The report indicated RC-Q d with C7 easily and was e her stuff. The report also ate reported they witnessed apping [C7's] face after he ally puzzle pieces or small be floor. The type of slapping resembles cupping [C7's] face he same manner from the e" cups his face after putting nd slapping [C7's] face real t dated 7/23/20, indicated C9 n 7/18/20, RC-Q was mean and housemates a lot when she further indicated RC-Q had room, didn't want C9 to call uty that day, and was loud and round. C9's report indicated vals everyday but RC-Q would her she would get hurt, and f the kitchen. The report e was being treated like a C9 reported at one point she o either go to her room or ort indicated C9 felt afraid of					
	in her room crying,	her to return, spent two hours and had "slept all day Sunday" it want to be around RC-Q					

If continuation sheet Page 12 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G208	B. WING	i			C 07/2020
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	i	
LAKE O	WASSO RESIDENCE				210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 154	reported she'd withe was unable to spear A facility reported C indicated C8 reported his house when RC by RC-Q many time and does not want to indicated when RC- 7/18/20, C8 had trie Operations and RC dude out." The report tried to explain what stated to C8, "I'm do indicated C8 stated and mean, saying s scheduled to work I weekend." The report housemate had ask phone number, RC- told him to mind his During interview with Director (OPD) on 7 confirmed two of fiv House 1 (where C7 regarding the allega not have time to con with the other client confirmed he had no perpetrator (RC-Q) working during the a why the investigation stated there had be here, he just did nor investigation). Furth interview with RC-R	bad about herself. C9 also essed RC-Q hit a resident who k for himself with a towel [C7]. EP report dated 7/24/20, ed he feels uncomfortable in -Q works and had been told es that she does not like him to talk to him. The CEP report -Q had worked the weekend of ed to talk to the Director of -Q had said, "Don't follow that ort indicated when [C8] had t he was doing, RC-Q had one". Further, the report RC-Q "treats me real rude he don't like me. When she is know its going to be a bad ort further indicated when a ted RC-Q for the supervisor's -Q yelled at him for that and	W	154			

If continuation sheet Page 13 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DATE COM	E SURVEY PLETED
		24G208	B. WING				C 07/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE O	WASSO RESIDENCE				210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 154	not be a whistle blo on anyone. RC-R d yelling between RC that she was in the Although OPD start confirmed he did no who had the potent alleged perpetrator aware RC-R "will no meant she potentia about the alleged a but no further quest although RC-R adm at the clients and co she did not report to agency/administrator with no evidence of A facility policy sign Maltreatment of Vul Procedure C. The F Report to the approt to the Minnesota Ac (MAARC) abuse ind sexual, psychologic harm, physical harm exploitation regardle perpetrator. The d administrator or adh collection of all inter evidence and pertir diagrams, review of allegation and provi action plan as imme Policy further indica mandated reporter believe a vulnerable	wer" and does not want to tell id say she may have heard -Q and another client (C9) but laundry room. The dhis investigation, he of interview all of the clients ial to be affected by the (AP). In addition OPD was of be a whistle blower" which lly could have known more buse than what was reported tions were asked. In addition nitted she witnessed RC-Q yell up her hands on C7's face,	W	154			

Facility ID: 00831

If continuation sheet Page 14 of 15

		AND HUMAN SERVICES					FORM	08/26/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		COM	E SURVEY PLETED
		24G208	B. WING					C 07/2020
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP C	ODE		
LAKE O	WASSO RESIDENCE				OWASSO BLVD NORTH DREVIEW, MN 55126			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
W 154	injuries of unknown involuntary seclusic property who fails to serious or recurring employment in pos with persons receiv licensing by the De	age 14 a source, exploitation, on, and misappropriation of o report that is found to be g may be disqualified from itions allowing direct contact ring services from programs partment of Human Services ota Department of Health.	W 1	54				

Facility ID: 00831

If continuation sheet Page 15 of 15



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed August 26, 2020

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

Re: Project Number HG208082C Event ID: 330Y11

Dear Administrator:

On 7/27/20, 7/28/20 and 7/29/20 an abbreviated survey was completed to investigate complaint HG208082C. 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,

Any Johour

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	BERTH TOXITON TOMBER.	A. BUILDING:			
	00831	B. WING			C 07/2020
IAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
AKE OWASSO RESIDENCE		ASSO BLVD NO /IEW, MN 5512			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
5 000 Initial Comments		5 000			
<ul> <li>144.56 and/or Minn 144.653, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of fit the Minnesota Depart Determination of wit corrected requires of requirements of the number and MN Ru indicated below. With several items, failure items will be conside Lack of compliance item of multi-part ru assessment of a fir violated during the corrected.</li> <li>You may request a that may result from orders provided that the Department wit notice of assessment On 7/27/20, 7/28/20 survey was comple HG208082C. The substantiated. No Figure 2005</li> </ul>	hether a violation has been compliance with all e rule provided at the tag ule number or MN Statute /hen a rule or statute contains re to comply with any of the dered lack of compliance. e upon re-inspection with any ule will result in the ne even if the item that was initial inspection was hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance. 0 and 7/29/20 an abbreviated eted to investigate complaint complaint was found to be licensing orders were issued. mpliance with requirements of Chapter 4665 requirements for				

330Y11

EMENT OF DEFICIENCIES     (X1) PROVIDER/SUPPLIER/CLIA     (X2) MULTIPLE CONSTRUCTION     0       PLAN OF DEFICIENCIES     24G208     NUMBER:     A. BUILDING     0       PLAN OF CORRECTION     24G208     NUMBER:     A. BUILDING     0       Idence     24G208     STREET ADDRESS, CITY, STATE, ZIP CODE     B. WING     7       Idence     210 N. Owasso Blvd, Shoreview, MN 55126     PLAN OF CORRECTION     PLAN OF CORRECTION	ED TOTHE / ED TOTHE / e been comp is which were taff e degree act of the follow taff e degree nec e degree nec ers of earned activities, an activities, an activities activities activit
EFICIENCIES ORRECTION ATEMENT OF DEFICIENCIES	Corrective meas Corrective meas Corrective meas Corrective meas Corrective meas Corrective meas Corrective meas Corrective meas Corrective meas Corrective meas A. Immediate acl 1. Staff will responded redirected to app reinforce the bet variable to provided redirected to app reinforce the bet as necessary. Au 2. Staff will supp emotion as necessary. Au 2. Staff will supp emotional suppo victim is monitor harm. Any signs 3. Incident is log would indicate h
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF FACILITY Lake Owasso Residence (x4) ID (FACUL DEFICIENCY STATEMENT OF DEFI	appl appl

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PLAN OF CORRECTION     Zenter ADDRess, CTN, StartE, ZIP. CODE       Sidence     210 N. Owasso Bivd., Shoreview, MN 651       SUMMARY STATEMENT OF DEFICIENCIES     D       ECACH DEFICIENCY SHOULD BE PRECEDED BY FULL     D       REGULATORY OR USC DEBNITPRING INFORMATION)     TAG       Cacharian     W122       Refer and reduce agressive behavioral symptoms for 1     W122       Refer and supervision for 1 of 1 clients     W122       Dome safe assessment and supervision for 1 of 1 clients     D       Reveed who was at risk for elopement.     D       Reveed who was at risk for elopement.     D       Drive operations directo     D       Reveed who was at risk for elopement.     D       Reveed elopement.     D <t< th=""><th>AND PLAN OF CORRECTION         20200         1/27/2020           Owesso Relative         3. WIUNG         A. BULUNG         1/27/2020           Owesso Relative         3. Winker ADRESS, CITY STATE         2.10 N. Owesso Blod, Shorewish, MI 657/28         1/27/2020           Owesso Relative         3. Winker Xinitekin of perfections at the interventions likely horizoned information of the intervention and other and statement into another another</th><th>STATEMENT OF DEFICIENCIES</th><th>PROVIDER/SUPPLIER/CLIA</th><th>(X2) MULTIPLE CONSTRUCTION</th><th>(X3) DATE SURVEY COMPLETED</th></t<>	AND PLAN OF CORRECTION         20200         1/27/2020           Owesso Relative         3. WIUNG         A. BULUNG         1/27/2020           Owesso Relative         3. Winker ADRESS, CITY STATE         2.10 N. Owesso Blod, Shorewish, MI 657/28         1/27/2020           Owesso Relative         3. Winker Xinitekin of perfections at the interventions likely horizoned information of the intervention and other and statement into another	STATEMENT OF DEFICIENCIES	PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Sidence         STREET ADDRESS, CITY STATE, ZIP CODE           sidence         2101N. Ovasses Bivd. Shoreview, MN 55126           SUMMARY STATEMENT OF DEFICIENCIES         PLAN OF CORRECTION           Sulf Adart Vision Be RECEDEN YF JULL         PLAN OF CORRECTION           Caling Field to identify field to provide and put in place to protect the alleget victim and others from further ham           Drive addition of the seasy vulnerable clients in the operation with further intervention to reduce the alleget victim and others from further ham           Drive addition of the seasy vulnerable clients in the operation with further intervention to reduce the alleget victim and others from further ham           Drive addition of the operation with further intervention to reduce the intervention to reduce any of ruture to the reviewed of and pointy and protector by off and the roll of ruture by and pointy and protector by off upt to the reviewed of and the roll of reduction are advected in the reviewed of and the roll of ruture to the reviewed of and the roll of ruture to the reviewed of and the roll of ruture by and pointy and protector by off upt to th	ADDRESS, CITV, 5TATE, ZIP CODE Owassos Bivd., Shoreview, MN 55126 Owassos Bivd., Shoreview, MN 55126 PREFIX RECTIVE ACTION SHOULD BE REFIX RECONSS-REFERRED TO THE APPROPRIATE DEFICIENCY Comt. Common findmentation 1. The on-duty supervisor will develop a short-term plan of protectin put into place while further interventions can be developed and put put into place while further interventions can be developed and put put into place while further interventions can be developed and put put into place while further interventions can be developed and put put into place while further interventions can be developed and put put into place while further interventions can be developed and put put into place while further interventions can be developed and put put into place while further interventions can be developed and put put into place while further interventions can be developed and put put into place while further interventions can be developed and put place. Diffector is responsible for monitoring the process the sustained adherence to the protocol. The administrative program to be trained on the revised policy and practice by 91/070200. Incidents are reviewed quarterly for quality assurance and will com be evaluated for effectiveness. Incidents are reviewed for effectiveness. Incidents are reviewed for correcting providing it is determined that other seleguards provide at these accused from correcting providing it is determined that other seleguards provide to these documents are made available to the facility. If deficiencies are ofted, an approved plated to the facility. If deficiencies are ofted, an approved plated to the facility. If deficiencies are ofted, an approved plated to the facility. If deficiencies are ofted, an approved plated to the facility. If deficiencies are ofted, an approved plated to the facility. If deficiencies are ofted, an approved plated to the facility. If deficiencies are ofted, an approved plated to the facility. If deficiencies are ofted, an approved pl		24G208	A. BUILDING B. WING	
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W122 cont. C. Immediate action put in place to protect the alleged victim and others from further harm in the non-dury supervisor will develop a short-term plan of protections to put into place while further interventions can be developed and put into place. D. The CIDP and the IDT will identify intervention to reduce the likelihood of future, train staff on changes, and monitor implementation. The operations director is responsible for monitoring the process to ensure sustained adherence to the protocol. The administrative program team will be trained on the revised policy and practice by 9/10/2020. Incidents are reviewed quarterly for quality assurance and will continue to be evaluated for effectiveness.	The failing failed to indicate it is an attempt to keep without Set of the provided that in an attempt to keep without Set of the provided that an attempt to keep without Set of the provided that an attempt to keep without Set of the provided that an attempt to keep without Set of the provided that an attempt to keep without Set of the provided that an attempt to keep without Set of the provided that an attempt to keep without Set of the provided that the provided that attempt to keep without Set of the provided that attempt to keep without Set of the provided that the provided that attempt to keep without Set of the provided that the provided the provided that the preprovided that the provided that the prepri	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATIO	ID PREFIX TAG		(X5) COMPLETION DATE
	The operations director is responsible for monitoring the process to ans usualized a dhremore on the protocol. The administrative program team v be trained on the revised policy and practice by 9/10/2020. Incidents are reviewed quarterly for quality assurance and will continue be evaluated for effectiveness. Incidents are reviewed quarterly for quality assurance and will continue be evaluated for effectiveness. Incidents are reviewed quarterly for quality assurance and will continue be evaluated for effectiveness. Incidents are reviewed quarterly for quality assurance and will continue be evaluated for effectiveness. Incidents are reviewed quarterly for quality assurance and will continue be evaluated for effectiveness. Incidents are reviewed quarterly for quality assurance and will continue be evaluated for effectiveness. Incidents are reviewed and the incidituation may be accurating providing if is determined that after effequared provide affect afforgation. Autors Directfors are discussible s0 days following the date of currention is the factorics are after affectivenes and for order affectivenes. Autors Directfor are discussible s0 days following the date of currention is a plan of currention are discussible s0 days following the date of currention are declared provides affect afforgation. Autors Directfor are discussible s0 days following the date of currents are a date and and a current and an approved plan of to according to the facility. If deficiencies are acted and are accurated at a proved plan of to according to the contract and are accurated at a plan of current and an approved plan of to according to the accurate accu	The facility failed to identify interventions likely to reduce behavioral incidents in an attempt to keep vulnerable clients in the home safe and reduce aggressive behavioral symptoms fc of 3 clients (C2) reviewed for abuse. The facility failed to provi adequate assessment and supervision for 1 of 1 clients (C5) reviewed who was at risk for elopement.	×	cont. C. Immediate action put in place to protect the alleged victim and others from further harm 1. The on-duty supervisor will develop a short-term plan of protections to put into place while further interventions can be developed and put into place. D. The QIDP and the IDT will identify intervention to reduce the likelihood of future, train staff on changes, and monitor implementation.	9/10/2020
	Incidents are reviewed quarterly for quality assurance and will continue be evaluated for effectiveness.         Incidents are reviewed quarterly for quality assurance and will continue be evaluated for effectiveness.         Incidents are for an asterial (1) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide suffic torgone participation.         Incident are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are fixed as following the date of survey whether or note a plan of correction is not operationable.         ANTORY DIREF_FOR'S OR PROVIDERSUPPLIER REPRESENTIVE       TITLE			The operations director is responsible for monitoring the process to ensur sustained adherence to the protocol. The administrative program team wibe trained on the revised policy and practice by 9/10/2020.	
	Electronic and ing with an asterist. (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide suffices. (See reverse for further instructions.) Except for nursing homes, the findings stated above are a disclosable 90 days following the date of strivey whether or not a plan of correction is previous and printings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are dired, an approved plan of correction is proved plan of correction.)         ANTORY DIRE_FOR'S OR PROVIDERSUPPLIER REPRESENTATIVE'S SIGNATURE       TITLE			incidents are reviewed quarterly for quality assurance and will continue to be evaluated for effectiveness.	
	ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide suffic s. (See <i>reverse for further instructions</i> .) 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 p 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 c end program participation. RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				
	ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide suffic s. (See <i>reverse for further instructions</i> ) 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 p 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 c ued program participation. RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESE <u>NT</u> ATIVE'S SIGNATURE TITLE				
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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: 24G208	IER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 7/27/2020	COMPLETED
NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE	Y, STATE, ZIP CODE			
Lake Owasso Residence	210 N. Owasso Blvd	210 N. Owasso Blvd., Shoreview, MN 55126			
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES       PREFIX     (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)	JLL PREFIX DN) TAG	PLAN O (EACH CORRECT) CROSS-REFERRED TO T	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
Based on interview and record review the facility failed to inform a legal guardian/parent of client safety concerns and obtain permission prior to	W124	The following has been accomplished for C5: 1. C5's team has been notified of the changes and agree the move is in his best interest.	the for C5: the changes and agree the i	move is in	9/10/2020
for rights.		At current, the facility does not have other residents that have the potential to be affected be the same deficient practice. The facility has added the following language to the Temporary Suspension of Services and De mission Policy to provide systemic change to address the deficient practice is not likely to reoccur:	ve other residents that have ent practice. The facility has any Suspension of Services c change to address the def	e the potential added the and De ficient	
Lingener		Transfers of residents to other homes within the facility are to be for good cause and completed in a time frame that allows the resident and guardian ample time to prepare for the transfer, unless there is an	mes within the facility are to ame that allows the resident or the transfer, unless there i	o be for good t and is an	
х.		<ul> <li>emergency.</li> <li>1. In emergencies, such as immediate medical or safety concerns, guardians will be contacted immediately of the move and the necessity of the move. Emergency moves are at the direction of the facility</li> </ul>	diate medical or safety conc diately of the move and the at the direction of the facility	cerns, necessity of ty	
		2. In accordance with Minnesota Statute 144.651-2, Subpart 29 of the Residents Bill of Rights, residents and guardians shall be notified in writing of proposed discharges or transfers, and the justifications for such	Statute 144.651-2, Subpart 3 s and guardians shall be noti ers, and the justifications for	29 of the tified in writing such	
		movement no more than 10 working days prior to enacting a proposed transfer within a facility. Moves may happen sooner at guardian discretion. 3. The resident, interested parties, case manager, and legal guardian is involved in planning for any transfer and receive the services necessary to	ing days prior to enacting a lay happen sooner at guardi s, case manager, and legal <u>g</u> fer and receive the services	proposed ian discretion. guardian is s necessary to	
		assist in preparing for movement, unless an emergency (medical) situation prevents that involvement. 4. Lake Owasso Residence will maintain information about the transfer,	unless an emergency (med naintain information about th	dical) situation he transfer,	
		Including the written houce of transfer will be kept in the person's record 5. The operations director is responsible for monitoring the process to ensure sustained adherence. "	aster will be kept in the perso onsible for monitoring the p	on's record. process to	
		<ul> <li>The administrative program team will be trained on the revised policy and practice by 9/10/2020.</li> </ul>	i will be trained on the revise	ed policy and	
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. ( <i>See reverse for further instructions</i> .) 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 at these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.	the institution may be exc dings stated above are disc ving the date these docum	Led from correcting providing it is dete losable 90 days following the date of su orts are made available to the facility. If	rmined that other safeguards pr vey whether or not a plan of cc deficiencies are cited, an approv	orovide sufficient p orrection is provide ved plan of correct	rotection to the ed. For nursing cion is requisite to
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S	re's signature	TITLE		(X6) DATE	
FORM CMS-2567 (02/99) Previous Versions Obsolete			If continua	If continuation sheet Page	e <u>1</u> of <u>1</u>

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers - Cont	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-0391
	EFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA Identification Number: 24G208	ER/CLIA IUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 7/27/2020	COMPLETED
NAME OF FACILITY Lake Owasso Re	sidence	STREET ADDRESS, CITY, STATE, ZIP CODE 210 N. Owasso Blvd., Shoreview, MN 55126	, STATE, ZIP CC Shoreview, N	ODE MN 55126		
(X4) ID PREFIX TAG	IMMARY STATEMENT OF DEFICIENCIES DEFICIENCY SHOULD BE PRECEDED BY FU STORY OR LSC IDENTIFYING INFORMATIO	PREFIX TAG	CKOS	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	d Be Eficiency)	(X5) COMPLETION DATE
	The facility failed to identify and implement interventions to reduce the likelihood of 3 clients (C1) reviewed for abuse. plan shotkld include C1, as care plan revisions and trai on changes to plan.	d training of staff	Based on the r correction has correction has 1. Program Dir Residential Co Adult Policy en reporter protec Reporting of M acknowledgme Completion Da will be tracked worked.) 2. A Memo Da will be tracked worked.) 2. A Memo Man personnel and personnel and completion Da staff completion Da	Based on the review of this area of concern, the following plan of correction has been completed: 1. Program Director/Program Supervisors will personally educate each Residential Counselor on pertinent portions of the facility's Vulnerable Adult Policy emphasizing mandatory reporting, failure to report, and reporter protections as in the policy and associated statute (626.557 Reporting of Mattreatment of Vulnerable Adults). RCs will sign acknowledgment of the individual session. Completion Date: 8/3/20 (Those not working during the completion period will be tracked and education completed at the next scheduled shift worked.) 2. A Memo from the Administrator will be written and be mandatory reading for each Residential Counselor and the potential associated bersonnel and legal implications of willful failure to report. The Memo will be loaded on the web based Learning and Development Contrandatory reporting of abuse/neglect and the potential associated personnel and legal implications of willful failure to report. The Memo will be loaded on the web based Learning and Development Center and assigned for completing by 8/6/20 will not return to work until completing the assignment. Program Director/Services Director/Program Supervisors completed a safety assessment on each/every resident Completion Date: 8/3/20 for will solve assignment.	ving plan of wing plan of the report, and atute (626.557 s will sign the completion period cheduled shift be mandatory the requirement for al associated oort. and Development e done. O Center. 8/6/20 for not return to work not return to work no treturn to work	8/6/2020
Any deficient patients. (Set homes, the a	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 date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued tororam participation.	e institution may be excu- gs stated above are disclo g the date these documen	sed from correctii ssable 90 days fol vts are made avail	ing providing it is determined that other safe; llowing the date of survey whether or not a p llable to the facility. If deficiencies are cited, a	guards provide sufficient polar of correction is provid an of correction is provid in approved plan of corrected plan of	protection to the led. For nursing tion is requisite to
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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDE IDENTIFI 24G208	Provider/Supplier/Clia Identification Number: 24G208	(X2) MULTIPLE CONSTRUCTION Building B. WING	(X3) DATE SURVEY COMPLETED 7/27/2020
NAME OF FACILITY I ake Owasso Re:	VAME OF FACILITY I ake Owasso Residence	STREET AI 210 N. Ov	DDRESS, CIT wasso Blvd.	STREET ADDRESS, CITY, STATE, ZIP CODE 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)	N) FL	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility failed to identify and implement interventions to reduce the likelihood of aggressive behaviors between clients for 1 of 3 clients (C1) reviewed for abuse.		W127	Based on the review of this area of concern, the following plan of correction has been completed: Lake Owasso will complete the following to address the physical aggression for resident C1: a. Complete a functional behavioral analysis for C1to identify the individual's behavioral management needs	8/6/2020
	Linder			<ul> <li>b. Create an in-depth behavior support plan which clearly describe the target behaviors, replacement behaviors, proactive and reactive strategies, and the use of positive reinforcement.</li> <li>c. Staff will be retrained on each affected resident's Individual Abuse Prevention Plans, Program Outcomes, Pro-social Coping Skills (BSP) and the facilities' Program Abuse Prevention place.</li> </ul>	 ع
				Completion Date: 8/3/20	
		•			
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Any deficienc patients. (See homes, the al continued pro	Any deficiency statement ending with an asterisk (*) denotes a deficiency which the in patients. (See <i>reverse for further instructions.</i> ) Except for nursing homes, the findings homes, the above findings and plans of correction are disclosable 14 days following th continued program participation.	the institutio dings stated ing the date	on may be excu above are discl these docume	recting providing it is determined that other safeguards provide /s following the date of survey whether or not a plan of correctic available to the facility. If deficiencies are cited, an approved pla	ent protection to the rovided. For nursing orrection is requisite to
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NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 210 N. Owseen Blud Shoreview MN	Y, STATE, ZIP CODE Shoreview MN 55126	56126		
(X4) ID PREFIX TAG	IMMARY STATEMENT OF DEFICIENCIES DEFICIENCY SHOULD BE PRECEDED BY FU VTORY OR LSC IDENTIFYING INFORMATIO			PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	) BE FICIENCY)	(XS) COMPLETION DATE
	Based on interview and document review, the facility failed to thoroughly investigate allegations	M1	Based on the review of this are correction has been completed:	Based on the review of this area of concern, the following plan of correction has been completed:	ng plan of	8/6/2020
I	or abuse for 1 of 1 client (C1) reviewed for start to client abuse. The facility further failed to thoroughly investigate client to client abuse for 2	approved	On 8/3/2020 , prog on the requirement	On 8/3/2020 , program supervisors were retrained by the services director on the requirement of immediate reporting suspected abuse	he services director ibuse	
	or 3 residents (C/ & C8) reviewed for client to client abuse.		The following langu Reporting policy:	The following language has been revised in the Vulnerable Adult Abuse Reporting policy:	able Adult Abuse	
			All mandated repor maitreatment, or m involuntary sectusis administrator or de which the report m assured. Allegation includes unknown source, e of property, a repoi (MAARC) is requirt immediately to the suspected maltreat administrator will a	All mandated reporters will report suspected allegations of abuse, neglect, maitreatment, or mistreatment, injuries of unknown source, exploitation, involuntary seclusion, and misappropriation of property to the administrator or designee immediately, unless the situation is unstable, in which the report must be made as soon as the safety of all residents is assured. Allegation includes abuse, neglect, maltreatment, mistreatment, injuries of unknown source, exploitation, involuntary seclusion, and misappropriation of property, a report to the Minnesota Adult Abuse Reporting Center (MAARC) is required. Reporting made by the facility must be done immediately to the appropriate authorities. If that person is involved in the suspected maltreatment, the facility for assessing if the report must be forwarded to MAARC.	s of abuse, neglect, urce, exploitation, to the ation is unstable, in of all residents is reatment, injurites of nd misappropriation orting Center ust be done ust be done in is involved in the am director or f the report must be	
		-	The administrator or or mattreatment, mistrea involuntary sectusion, missing persons from MAARC immediately.	The administrator or designee will report all allegations of abuse, neglect, maitreatment, mistreatment, injuries of unknown source, exploitation, involuntary sectusion, and misappropriation of property, elopement or missing persons from program to the administrator or designee and MAARC immediately.	s of abuse, neglect, e, exploitation, /, elopement or Jesignee and	
		. <u></u>	Facility staff was n	Facility staff was retrained by 8/6/2020		
ny deficiency itients. (See r imes, the abc intinued prog	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 <i>reverse for further instructions.</i> ) 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 days following the date 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.	ne institution may be excu ngs stated above are discl ig the date these documer	sed from correcting pr osable 90 days followin nts are made available	oviding it is determined that other safegue the date of survey whether or not a plate to the facility. If deficiencies are cited, and	uards provide sufficient an of correction is provic approved plan of correc	protection to th ded. For nursing ction is requisite
ABORATOR	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	'S SIGNATURE	TITLE	Alministra for	(X6) DATE るけい)	DATE   (J) 2 J

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	EFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	ERCLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING (X2) DATE SURVEY COMPLETED B. WING (X2) AUTOR (X2) (X2) (X2) (X2) (X2) (X2) (X2) (X2)	OMPLETED
NAME OF FACILITY	sidence	STREET ADDRESS, CITY, STATE, ZIP CODE 210 N. Owasso Blvd., Shoreview, MN	55126	
(X4) ID PREFIX TAG	IMMARY STATEMENT OF DEFICIENCIES DEFICIENCY SHOULD BE PRECEDED BY FU ATORY OR LSC IDENTIFYING INFORMATIO	ID PREFIX TAG	PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE ED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on interview and document review, the facility failed to ensure that all allegations of	w153	Based on the review of this area of concern, the following plan of correction has been completed:	8/6/2020
	mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other	approved	On 8/3/2020 , program supervisors were retrained by the services director on the requirement of immediate reporting suspected abuse.	
	officials in accordance with State law through established procedures.		The following language has been revised in the Vulnerable Adult Abuse Reporting policy:	
			All mandated reporters will report suspected allegations of abuse, neglect, maltreatment, or mistreatment, injuries of unknown source, exploitation, involuntary seclusion, and misappropriation of property to the administrator or designee immediately, unless the situation is unstable, in which the report must be made as soon as the safety of all residents is assured.	
			Allegation includes abuse, neglect, maltreatment, mistreatment, injuries of unknown source, exploitation, involuntary sectusion, and misappropriation of property, a report to the Minnesota Adult Abuse Reporting Center (MAARC) is required. Reporting made by the facility must be done immediately to the appropriate authorities. If that person is involved in the suspected maltreatment, the facility's operations program director or administrator will assume responsibility for assessing if the report must be forwarded to MAARC.	
			The administrator or designee will report all allegations of abuse, neglect, mattreatment, mistreatment, injuries of unknown source, exploitation, involuntary sectusion, and misappropriation of property, elopement or missing persons from program to the administrator or designee and MAARC immediately.	
			Facility staff was retrained by 8/6/2020	
/ deficienc lents. (See nes, the at	Any deficiency statement ending with an asterisk (*) denotes a deficiency which the patients. (See reverse for further instructions.) Except for nursing homes, the findin homes, the above findings and plans of correction are disclosable 14 days following	e institution may be excu gs stated above are discl the date these docume	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 <i>reverse for further instructions.</i> ) 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 are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings the date 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	stection to the structure of the structu
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	STATEMENT OF DEFICIENCIES	(X1) PROVIDE IDENTIFI 24G208	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	COMPLETED
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NAME OF FACILITY		210 N OM	DRESS, CITY,	STREET ADDRESS, CITY, STATE, ZIP CODE 210 N. Owasso Blvd - Shoreview - MN 55126	5106 		
(X4) ID PREFIX	IMMARY STATEMENT OF DEFICIENCIES		ID PREFIX	(EAC	EACH CORRECTION	BE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	_	TAG	CROSS-REF	CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	FICIENCY)	DATE
	Based on observation, interview and document review the facility failed to provide client choice for 1 of 1 clients (C5) reviewed when C5 was abruptly moved from House 2 to House 7 as a response to an elopement concern but without involvement for the client or his family, without time to process or prepare for the move and without involvement in the moving and packing process.			The rollowing has been accontrie the rollowing has been notified it. C5's team has been notified involved in planning for any tr assist in preparing for movem prevents that involvement. 2. In anticipation of a resident explanation of the reason for ask questions or refuse the m be introduced to new peers, s the opportunity to help pack, have the opportunity to assist make their space comfortable 4. Lake Owasso Residence w including the written notice of 5. The operations director is ensure sustained adherence. The administrative program te practice by 9/30/2020.	The rollowing has been accomplished for Cost 1. C5's team has been notified of the changes and agree the move is in his best interest. 1. The resident, interested parties, case manager, and legal guardian is involved in planning for any transfer and receive the services necessary to assist in preparing for movement, unless an emergency (medical) situation prevents that involvement. 2. In anticipation of the reason for the proposed move and an opportunity to ask questions or refuse the move. If the move proceeds the resident will be introduced to new peers, see the room to which they will move, have the opportunity to help pack, move, and unpack belongings. Residents will have the opportunity to assist in arranging furniture, decorate walls, and to make their space comfortable and to their liking. 4. Lake Owasso Residence will maintain information about the transfer, including the written notice of transfer will be kept in the person's record. 5. The operations director is responsible for monitoring the process to ensure sustained adherence. The administrative program team will be trained on the revised policy and practice by 9/30/2020.	ee the move is in egal guardian is rvices necessary to v (medical) situation ant will be given an in opportunity to s the resident will y will move, have lings. Residents will corate walls, and to corate walls, and to to be record. the process to revised policy and revised policy and	0202/01/6
					i dina te is determinant that a that a faar		
Any deficient patients. (See homes, the al continued pro	Any dericiency statement ending with an asterisk (*) denotes a dericiency which the institution may be excused from correcting provising the statement ending with an asterisk (*) denotes a dericient protection to inspection is provided. For nursing house, 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.	the Institution lings stated a ing the date t	n may be excuse bove are disclosi hese documents	a from correcting prov able 90 days following s are made available to	right is determined that other safeg the date of survey whether or not a pl the facility. If deficiencies are cited, an	an of correction is provide summer an of correction is provide approved plan of correction is the second structure approved plan of correction	indiction to the led. For nursing tion is requisite to
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	(X3) DATE SURVEY COMPLETED 7/27/2020		) BE EFICIENCY)	ctions have been	al assessments and ent outcome for C3 current social ig on 9/10/2020 and	treatment, including s as needed on	tor for compliance.				juards provide sufficient lan of correction is prov n approved plan of corre		If continuation sheet Page
	(X2) Multiple construction A. Building B. Wing	ODE MN 55126	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	Based on review of the documentation, the following actions have been taken to correct the noted deficit:	The QIDP have reviewed the comprehensive functional assessments and has revised the methodology of the money management outcome for C3 and C2 to participate in financial transactions despite current social restrictions. The outcome has been provided for training on 9/10/2020 and completed by 9/20/20.	The program team was trained on elements of active treatment, including the QIDP responsibility to monitor and adapt programs as needed on 9/9/2020.	This will be monitored by the operations program director for compliance.	•		•	ing providing it is determined that other safe. Illowing the date of survey whether or not a p Ilable to the facility. If deficiencies are cited, a	Alminis brada	14 O
	LIER/CLIA NUMBER:	STREET ADDRESS, CITY, STATE, ZIP CODE 210 N. Owasso Blvd., Shoreview, MN 55126	CRO	Based on revi taken to corre	The QIDP have review has revised the metho and C2 to participate i restrictions. The outco completed by 9/20/20.	The program the QIDP resp 9/9/2020.	This will be m		 	 	cused from correcti closable 90 days fo iemts are made avai		-
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	DDRESS, CI vasso Blv	D PREFIX TAG	257	approved				J		on may be ex above are dis these docum	URE	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	עמאב OF FACILודץ Lake Owasso Residence	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	Based on interview and document review, the facility failed to update, revise or change financial	programs for 2 or 4 clients (Co and Co) reviewed in the sample who went off campus to implement their money management programs.						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 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 documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.		FORM CMS-2567 (02/99) Previous Versions Obsolete
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	STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	LIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	<pre>COMPLETED</pre>
	AND PLAN OF CORRECTION	24G208		A. BUILDING B. WING	7/27/2020	
NAME OF FACILITY Lake Owasso Re	VAME OF FACILITY Lake Owasso Residence	STREET ADDRESS, CITY, STATE, ZIP CODE 210 N. Owasso Blvd., Shoreview, MN	ITY, STATE, ZIP CODE d., Shoreview, MN 55126	NDE NN 55126		
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	Based on interview and document review the facility failed to ensure C5 received his prescribed diet order due to his swallowing difficulties.	W331	Based on the re staff that provid Document revie "pureed diet, es prior to next bit	Based on the review of this area of concern, it has been identified that the staff that provided the information was incorrect. Document review indicated the dietary recommendations does state: "pureed diet, eat slow, take small bites and to swallow prior to next bite and honey thicken liquids." as prescribed.	identified that the s does state: ed.	9/10/2020
	Luperen		A dietary recon posted in a visi Language in di language rathe retrained on the 8/3/2020.	A dietary recommendation summary is provided to each home and is posted in a visible area in kitchen for staff information. Language in diet recommendation summaries revised to read as "plain language rather than industry short hand. Staff directly impacted will be retrained on the language and provided clarification on C5 diet. Completed 8/3/2020.	r home and is o read as "plain mpacted will be C5 diet. Completed	
			A training expla 9/10/2020 and policy.	A training explaining dietary textures has been assigned to all staff on 9/10/2020 and will be completed within 30 day's of assignment per training policy.	t to all staff on gnment per training	
				\		
Any deficíenc patients. (See homes, the al continued pro	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. ( <i>See reverse for further instructions</i> .) 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 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.	the institution may be ex dings stated above are di ing the date these docum	ccused from correctin sclosable 90 days foll nents are made avails	ig providing it is determined that other safegu owing the date of survey whether or not a pla able to the facility. If deficiencies are cited, an	ards provide sufficient n of correction is provic approved plan of corre	protection to the ded. For nursing ction is requisite to
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	(X3) DATE SURVEY COMPLETED	7/27/2020			) BE :FICIENCY)	ctions have been	al assessments and medication ovided for training	ation program: If a ive functional DP will review the ormal programming d an informal e.	tor for compliance.	e on 9/9/2020.		juards provide sufficient lan of correction is provic n approved plan of correc	(X6) DATE	If continuation sheet Page <u>1</u>
		A. BUILDING B. WING	CODE		PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	Based on review of the documentation, the following actions have been taken to correct the noted deficit:	The QIDP have reviewed the comprehensive functional assessments and has developed an outcome for C4 to participate in self medication management programming. The outcome has been provided for training and completed by 9/20/20.	Procedural changes in discontinuance of a self-medication program: If a medication program is determined by the comprehensive functional assessment to no longer benefit the individual, the QIDP will review the assessments with the IDT, including the physician. If formal programming is discontinued, it will be noted in physicians orders and an informal program to sustain current skill level will be put in place.	This will be monitored by the operations program director for compliance.	The program team was trained on the revised practice on 9/9/2020.		ting providing it is determined that other safeg collowing the date of survey whether or not a p ailable to the facility. If deficiencies are cited, ar	Administration	ή α
	NUMBER:		STREET ADDRESS, CITY, STATE, ZIP CODE	Owasso Blvd., Shoreview, MN 55126	Š	Based on rev taken to corr	The QIDP ha has develope managemen and complete	Procedural c medication p assessment assessments is discontinu program to s	This will be r	The prograr	· · · · · · · · · · · · · · · · · · ·	xcused from correc isclosable 90 days f nents are made av	TITLE	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	24G2D8	T ADDRESS, C	. Owasso Blv	ID PREFIX TAG	371	approved					fution may be ex tred above are di date these docun	NATURE	
	(X1) PI	- 14	STREE	210 N.	ies By Full (Ation)	modivation						which the inst he findings sta following the (	IATIVE'S SIG	· .
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	STATEMENT OF DEFICIENCIES	AND PLAN OF CORRECTION	AGILITY	Lake Owasso Residence	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	Based on observation, interview and document review, the facility failed to reassess and develop a formal medication program for 1 of 4 clients	(C4) who had the ability to be involved in setting up medications ordered by primary physician.	. ~				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 <i>reverse for further instructions.</i> ) 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 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	FORM CMS-2567 (02/99) Previous Versions Obsolete
DEPARTMENT ON CENTERS FOR MI	0		NAME OF FACILITY	Lake Owas	(X4) ID PREFIX TAG		_					Any deficiency patients. (See homes, the ab continued pro	LABORATO	FORM CMS-

DEPARTMENT O CENTERS FOR M	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES			0	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 7/27/2020	COMPLETED
NAME OF FACILITY Lake Owasso Re	sidence	STREET ADDRESS, CITY, STATE, ZIP CODE 210 N. Owasso Blvd., Shoreview, MN	street address, city, state, zip code 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)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Based on interview and document review the facility failed to ensure that personnel on all shifts	W4	Based on the review of this area of concern, the following is the plan of correction:		9/10/2020
	were trained to perform assigned tasks during evacuation drills.	approved	The Emergency and Special Procedures Training was completed by all staff on 8/6/2020.	mpleted by all	
			The services director is responsible for monitoring completion of trainings to ensure sustained adherence to time lines in the Orientation and Training Policy.	etion of trainings ation and	
			The administrative program team will be trained on the revised policy and practice by 9/10/2020. The COVID-19 Policy was updated on 9/8/2020 to include the following	vised policy and e the following	
			"Due to the inadvisability of quarterly fire drills that move and mass staff "Due to the inadvisability of quarterly fire drills that move and mass staff together, Lake Owasso residence will provide training instructing employees, including existing, new or temporary employees, on their current duries, life safety procedures and the fire protection devices in their concent of the protection devices in their	and mass staff structing ses, on their on devices in their	
			is Facility fire drills will be suspended upon assessment of increased risk by the director of nursing."	f încreased risk	
			Supervisors will be provided retraining on continuous monitoring of fire drill procedures and practices by the services director by 9/10/2020.	nitoring of fire drill )/2020.	
			The operations director is responsible for monitoring the application of fire drills in the facility.	application of fire	
Any deficiency patients. (See homes, the ab continued pro	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 <i>reverse for further instructions</i> .) 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 the date date of survey whether or not a plan of correction is provided. For nursing continues, 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 dited, an approved plan of correction is requisite to continue brown and provided in the date these documents are made available to the facility. If deficiencies are dited, an approved plan of correction is requisite to continue brown and provided.	institution may be excu sstated above are disc the date these docume	ket from correcting providing it is determined that other safeguar. sed from correcting providing it is determined whether or not a plan o osable 90 days following the date of survey whether or not a plan of the are made available to the facility. If deficiencies are cited, an ap	ds provide sufficient pr of correction is provide pproved plan of correcti	otection to the d. For nursing on is requisite to
LABORATO	REALER REPRESENTAT	TVE'S SIGNATURE	TITLE A durins rhafn	(X6) DATE	24
FORM CMS-	FORM CMS-2567 (02/99) Previous Versions Obsolete			If continuation sheet Page.	of

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EXAMOL       B. WING         Side       FILT DATE       B. WING       ILT.LOUD         Side       FILT DATE       EXAMOL       EVANO F CORFECTION       ILT.LOUD         SUMMARY STATEMENT OF DEFICIENCY       SILON SHOULD BE RECENCED SY FILL       TAG       EXAMOL       EVANO F CORFECTION       ILT.LOUD         SUMMARY STATEMENT OF DEFICIENCY       SILON SHOULD BE RECENCING       ILT.LOUD       EVANO F CORFECTIVE ACTION SHOULD BE       ILT.LOUD         SUMMARY STATEMENT OF DEFICIENCY       RECULATION OF ORE SHORE ACTION       INC.       EXAMOL       CORFECTIVE ACTION SHOULD BE       ILT.LOUD         SUMMARY STATEMENT OF DEFICIENCY       RECULATION OF ORE TO THE ACTION SHOULD BE       ILT.LOUD	OF DEFICIENCIES	(1) PROVIDER/SUPPL IDENTIFICATION   24G208	× (X)	(X3) DATE SURVEY COMPLETED	ETED
STREET         STRET         ADDRESS, CTN         STRET         ADDRESS, CTN         STRET         ADDRESS, CTN         FLAN OF         CORRECTION         Execution         Constraction         Constraction <thconstraction< th="">         Constracting</thconstraction<>	CONNECTION		ന്	112112020	
ID         PLAN OF CORRECTION         ID           MMARY STATEMENT OF DEFICIENCIES         ID         PLAN OF CORRECTION         REEK         CROSS-REFERENCE ACTION         ID           Crostons, interview and document review, failed to tractions, interview and document review, failed to the section for 2 of 2 houses (houses 4 and 5)         WASS         Based on the review of this area of concern, the following is the plan of correction:         A           Areations, interview personal equipment         A CONDU-19 R FREERED FOR THAT IS poly of through the plan of correction:         A         A           A weat of protection for 2 of 2 houses (houses 4 and 5)         MASS         Based on the review of this area of concern, the following guidelines which address the concerns noted in intel (2015) - 5557. At the time of the survey, staff were out of compliance to the biginuing of thair next aftif which address the concerns noted in intudue goggles. Each staff wes indified of the oggle requirement at the biginuing of thair next aftif wes indified of the oggle requirement at the biginuing of thair next aftif wes indified of the oggles requirement at the biginuing of their and survey, staff were out of compliance to the oggles. Each staff were indified of the entracore screening. See Section II: 8.5.           Yai program staff have been trained to metal deperton when on facility grounds, including in break rooms or other spaces where they might encounter co-workens.           Yai program staff have been trained to metal dometation and south the services director by VICDD. A PFE breach of the services director and doministration.           Supervisors will be provided retraining	sidence	TREET ADDRESS, CIT 10 N. Owasso Blvd			
<ul> <li>W455 Based on the review of this area of concern, the following is the plan of correction:         <ul> <li>A COVID-19 Response Policy was authored on 6/23/2020 and provided to correction:                 <ul></ul></li></ul></li></ul>	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY SHOULD BE PRECEDED BY FU STORY OR I SC IDENTIFYING INFORMATIO	L PREFIX			LETION
approved	Rase on observations interview and document review fail	M4	Based on the review of this area of concern, the followin		20
<ul> <li>survey, staff were out of compliance to the policy.</li> <li>7/28/2020: Language was added to include goggles. Each staff wes notified of the goggle explorement at the beginning of their next shift during the matter sectors.</li> <li>"Staff are always required to wear a face covering and eye protection when mean material is 3."</li> <li>"Staff are always required to wear a face covering and eye protection when mean matter sectors."</li> <li>All program staff have been trained on the additional language by 8/3/2020.</li> <li>Supervisors will be provided tetraining on continuous monitoring and correcting staff and visitor compliant of and assess for exposure concerns and submit to the services director by visitor compliant and assess for exposure concerns and submit to the services director wall continues to monitoring and correcting staff who are non-compliant and assess for exposure concerns and submit to the services director wall continue to monitor, document, and address concerns with PFE compliance.</li> </ul>	ensure all staff were wearing protective personal equipmel (PPE) eye protection for 2 of 2 houses (houses 4 and 5) observed.		correction: A COVID-19 Response Policy was authored on 6/23/20 employees for training. This policy did include the follow which address the concerns noted in the CMS-2567. At	220 and provided to ving guidelines t the time of the	
7/23/2020: Language was added to include goggles. Each staff was notified of the goggle requirement at the beginning of their next shift during the enternore screening. See Section II: 8.5 "Shift are anveys required to ware a fabe covering and eye protection when on facility grounds, including in break rooms or other spaces where they might encounter co-workers." All program staff have been trained on the additional language by 8.2/2020. A presenting and correction staff who are non-compilating and correction and address concerns and submit to the services director will be feat of a staff who are non-compilating and correction and address concerns with PPE compilation.			survey, staff were out of compliance to the policy.		
All program staff have been trained on the additional language by 8/3/2020. Supervisors will be provided retraining on continuous monitoring and correcting staff and visitor compliance to COVID practices and procedures by the services director by 9/10/2020. A PPE breach long will be kept of staff who are non-compliant and assess for exposure concerns and submit to the services director and administrator. The operations and services director will optime to monitor, document, and address concerns with PPE compliance.			7/28/2020: Language was added to include goggles. Ea notified of the goggle requirement at the beginning of th the entrance screening. See Section II: B.5. "Staff are always required to wear a face covering and twhen on facility grounds, including in break rooms or oth they might encounter co-workers."	ach staff was neir next shift during eye protection ther spaces where	
Supervisors will be provided retraining on continuous monitoring and correcting staff and Visitor compliance to COVID practices and procedures by the services director by 9/10/2020. A PPE breach long will be kept of staff who are non-compliant and assess for exposure concerns and submit to the services director and administrator. The operations and services director with PPE compliance.			All program staff have been trained on the additional lar 8/3/2020.	nguage by	
The operations and services director will continue to monitor, document, and address concerns with PPE compliance.			Supervisors will be provided retraining on continuous m correcting staff and visitor compliance to COVID practic by the services director by 9/10/2020. A PPE breach lor staff who are non-compliant and assess for exposure $\alpha$ to the services director and administrator.	nonitoring and ces and procedures ng will be kept of oncerns and submit	
			The operations and services director will continue to mo and address concerns with PPE compliance.	onitor, document,	
	rogram participation. DRY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'	S SIGNATURE			
continued program participation. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESEMPATIVE'S SIGNATURE TITLE A Continued of the Continued of t					4



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email December 7, 2020

RE: Event ID: 330Y12

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

RE: Event ID: 330Y12

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,

Any Johoon

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

Lake Owasso Residence December 6, 2020 Page 2

		AND HUMAN SERVICES			FORM	APPROVED
STATEMENT	TOF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE COM	0938-0391 E SURVEY PLETED
		24G208	B. WING _			-C 03/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE OW	WASSO RESIDENCE			210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENT	rs	{W 00	0}		
	11/3/20, to determin deficiencies issued 7/27/20. The facilit met substantial con 42 CFR 483. Subpa	as conducted on 11/2/20 and he compliance with federal during a full survey exited on y was determined to have not npliance with the regulations at art I, for Intermediate Care uals with Intellectual ).				
{W 153}	The Condition of Participation at 42 CFR 483.420 Client Protection, was found to be back in compliance with only standard deficiencies reissued.			3}		
	mistreatment, negle injuries of unknown immediately to the	isure that all allegations of ect or abuse, as well as source, are reported administrator or to other nce with State law through ures.				
	Based on interview facility failed to imm	s not met as evidenced by: and document review the nediately report client to client ents (C9) reviewed for abuse.				
	Findings included:					
		pdated 6/22/20, indicated she oderate intellectual disability				
	2:50 p.m. indicated	Form (IRF) dated 10/25/20, at C9 was getting her laundry				
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	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.

PRINTED: 12/06/2020

		AND HUMAN SERVICES				RINTED: 12/06/2020 FORM APPROVED MB NO. 0938-0391		
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED	
		24G208	B. WING				-C 03/2020	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				2	10 OWASSO BLVD NORTH			
	WASSO RESIDENCE			S	SHOREVIEW, MN 55126			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{W 153}	<ul> <li>while yelling. C9 th started screaming a then backed her int and pulled her hair.</li> <li>them and provided Staff continued to o keep them apart for redirection to maint and others. C9 sus that included a scra self-injurious behave the nurse was calle Aquaphor was appl made to the state a</li> <li>Records indicated of director of operation the SA.</li> <li>During an interview stated after an incid client injuries and d nurse then fills out the supervisor. The D0 supervisor onsite the not submit a report stated there was a Monday morning the submit a report to the At 12:15 p.m. the D have been reported when I came in and stated it should have incident occurred.</li> <li>issues in the past w DO identified the nur-</li> </ul>	en stubbed her toe and and swearing. A housemate o a wall and scratched her Staff immediately separated redirection to both clients. observe the clients and helped r the rest of the evening with ain the safety of themselves stained minor injury to her face atch and a bloody lip from for (SIB). The report indicated d. Staff cleansed her lip, ied and ice. No report was gency (SA) at the time. on 10/26/20, at 9:51 a.m. ns (DO) submitted a report to f on 11/3/20, at 12:09 p.m. DO dent, the nurse assesses the oes what is needed. The the IRF and gives to the D stated there was no nat evening and the nurse did to the SA. The DO stated all report to the SA. The DO supervisor on call until at could have been called to	{W 1	53}				

If continuation sheet Page 2 of 3

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
AND FLAN C	of correction	IDENTIFICATION NOMBER.	A. BUILDII	NG	R	
		24G208	B. WING _			3/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH		
LAKE O	NASSO RESIDENCE			SHOREVIEW, MN 55126		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 153}	Continued From pa	ge 2	{W 15	3}		
{W 455}	Vulnerable Adults re A. All mandated rep allegations of abuse mistreatment, injuri exploitation, involur misappropriation of or designee immed unstable, in which t soon as the safety of B. Allegation include maltreatment, mistr source, exploitation misappropriation of required. Reporting done immediately to C. The facility must 11. Resident to res willful, the action(s) unreasonable, conf punishment with like harm, pain, or ment INFECTION CONT CFR(s): 483.470(l)( There must be an a prevention, control, and communicable	property to the administrator iately, unless the situation is he report must be made as of all residents is assured. es abuse neglect, reatment, injuries of unknown i, involuntary seclusion, and property, a report to the SA is g made by the facility must be of the appropriate authorities. immediately report: ident altercations which are result in infliction of injury, inement, intimidation or elihood of resulting physical tal anguish. ROL 1) active program for the and investigation of infection	{W 45	5}		

If continuation sheet Page 3 of 3

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