DEPARTMENT OF HEALTH

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.

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:

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,

Amy Johnson

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 08/07/2020

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

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W 000	INITIAL COMMENTS On 7/27/20, 7/28/20 and 7/29/20, 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 issued at W122, W127. Additionally, as a result of the investigations W154 was also cited. An Immediate Jeopardy (IJ) was identified at W127 on 7/29/20, at 2:16 p.m. and removed 8/7/20, at 11:45 a.m. The Immediate Jeopardy began on 7/18/20, when alleged perpetrator (AP) resident counselor (RC)-Q was witnessed by clients and staff person to be yelling, cupping a client's face and hitting the client with a towel. When interviewed, RC-R verified she had observed RC-Q's actions but had not reported it due to fear of retaliation by RC-Q, did not want to be a "whistle blower" and wanted to remain anonymous. The director of operations (DO) was notified of the IJ on 7/29/20, at 2:16 p.m. The IJ was removed on 8/7/20, at 11:45 a.m. when the facility had implemented measures to assess and ensure all clients safety, and determined strategies to ensure staff would report incidents of abuse.	W 000		
W 122	CLIENT PROTECTIONS	W 122		

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

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W 122	Continued From page 1 CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection was not met. The facility failed to protect 4 of 4 clients (C7, C8, C9 and C10) from verbal and physical abuse, and failed to implement protocols for reporting and investigating. Findings include: See W127: The facility failed to protect 4 of 4 clients (C7,C8 ,C9 and C10) from abuse.	W 122		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to protect 4 of 4 clients (C7, C8, C9 and C10) from physical/verbal abuse by a staff member (talking rough, yelling, cupping a client in the face and hitting with a towel). In addition, the facility failed to address and implement strategies when management at the facility had knowledge	W 127		

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of mandated reporters refusing to report abuse as required by law and facility policy. This resulted in an immediate jeopardy (IJ) to the health and safety of all 4 clients.

The Immediate Jeopardy began on 7/18/20, when alleged perpetrator (AP) resident counselor (RC)-Q was witnessed by clients and staff person to be yelling, cupping a client's face and hitting the client with a towel. When interviewed, RC-R verified she had observed RC-Q's actions but had not reported it due to fear of retaliation by RC-Q, did not want to be a "whistle blower" and wanted to remain anonymous. The director of operations (DO) was notified of the IJ on 7/29/20, at 2:16 p.m. The IJ was removed on 8/7/20, at 11:45 a.m. when the facility had implemented measures to assess and ensure all clients safety, and determined strategies to ensure staff would report incidents of abuse.

Findings include:

C7's Profile sheet updated 7/27/20, indicated he had profound intellectual disability. C7's Individual Abuse Prevention Plan (IAPP) dated 4/16/20, indicated he was susceptible to abuse, and is likely to cooperate in an abusive situation and has inability to be assertive. In addition he would be unable to report incidents of abuse.

C 8's Profile sheet updated 7/27/20, indicated he had mild intellectual disability, schizoaffective disorder, adjustment disorder with mixed emotions and conduct, pervasive development disorder. IAPP dated 5/21/20, indicated C 8 was susceptible to abuse, inability to identify potentially dangerous situations, may have inappropriate interactions with others which made

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him vulnerable to abuse and an inability to deal with verbally/physically aggressive persons.

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 had 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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items he finds on the floor. The type of slapping that was described resembles cupping [C7's] face with both hands in the same manner from the movie "Home Alone" cups his face after putting after shave on it, and slapping [C7's] face real hard."

A facility CEP report dated 7/23/20, indicated C 9 had reported that on 7/18/20, RC-Q was mean and yelled at her and housemates a lot when she works. The report further indicated RC-Q had told C 9 to go to her room, didn't want C 9 to call the supervisor on duty that day, and was loud and bossing residents around. C 9's report indicated she helped with meals everyday but RC-Q would not let her, had told her she would get hurt, and told her to get out of the kitchen. The report indicated C 9 felt she was being treated like a child. In addition, C 9 reported at one point she was told by RC-Q to either go to her room or move out. The report indicated C 9 felt afraid of RC-Q, did not want her to return, spent two hours in her room crying, and had "slept all day Sunday" because she did not want to be around RC-Q who made her feel bad about herself. C 9 also reported she had witnessed RC-Q hit a resident who was unable to speak for himself with a towel [C7].

A facility reported CEP report dated 7/24/20, indicated C 8 reported he feels uncomfortable in his house when RC-Q works and had been told by RC-Q many times that she does not like him and does not want to talk to him. The CEP report indicated when RC-Q had worked the weekend of 7/18/20, C 8 had tried to talk to the Director of Operations and RC-Q had said, "Don't follow that dude out." The report indicated when [C 8] had tried to explain what he was doing, RC-Q had

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stated to C 8, "I'm done." Further, the report indicated C 8 stated RC-Q "treats me real rude and mean, saying she don't like me. When she is scheduled to work I know its going to be a bad weekend." The report further indicated when a housemate had asked RC-Q for the supervisor's phone number, RC-Q yelled at him for that and told him to mind his own business.

During interview with the facility's Operations Program Director (OPD) on 7/27/20, at 9:42 a.m. discussed his interview with RC-R (1 of 2 staff working weekend of alleged abuse) stating RC-R told him she, "will not be a whistle blower" and does not want to tell on anyone. The OPD stated RC-R had stated she may have heard yelling between RC-Q and another client (C 9), but that she was in the laundry room.

During interview with C 9 on 7/27/20, at 11:47 a.m. C 9 stated on the weekend of 7/18/20, RC-Q was yelling at everyone, hitting C7 with a towel on his chest multiple times because he was trying to take her phone and water bottle. C 9 reported C7 got mad when RC-Q hit him, so he [C7] started hitting himself on the head and RC-Q just walked away. C 9 stated her housemates C 8 and C10, also witnessed the abuse as well as RC-R who did nothing to stop it. C 9 said, "The abuse has been going on for a month." C 9 said it makes her and her housemate stay in their rooms a lot adding, "[RC-Q] restricts us from using the phone because she thinks clients will call 911 for help." C 9 also reported RC-Q had hit her in the chest several months ago when she had initially refused to take her medications. C 9 confirmed she did not report this to anyone, stating she was afraid.

During interview with C 8 on 7/27/20, at 12:06

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p.m. C 8 reported the last weekend RC-Q worked (7/18/20) was "the worst weekend ever." C 8 stated RC-Q was "mean and rude, ignoring me and telling me that she did not want to talk to me." C 8 stated he wished RC-Q wanted to talk to him. C 8 also said he is afraid of RC-Q. C 8 said RC-Q had not hit him before, but "has slapped [C7] in the face several times because [C7] was throwing papers." C 8 also stated RC-Q hit C7 with a towel because C7 was messing with RC-Q's purse. C 8 stated RC-Q had called him ugly and had been treating him like this for years so he wished RC-Q would go to another house to work. C 8 confirmed he had not reported the abuse previously.

Attempts were made to interview C7, who was determined not to be interviewable.

RC-R was interviewed on 7/27/20, at 2:00 p.m. and stated she had worked the weekend of 7/17/20, and heard RC-Q yelling at the clients in the house, but did not want to be a "whistle blower." RC-R further stated RC-Q is intimidating to the clients in House 1, and stated she had observed RC-Q cup her hands on C7's face. RC-C stated she did not know why RC-Q did that to C7, but just wished the clients could be treated with respect. Furthermore, RC-R stated she was afraid to report anything due to the hostile environment at the facility and stated even though she is a mandated reporter, she will not report due to her fear.

RC-S stated during interview 7/27/20, at 3:24 p.m. he worked the weekend of 7/18/20, but did not work with RC-Q often. RC-S stated RC-Q can be intimidating and hostile to the clients in House 1. Additionally, RC-S stated, "Some of the staff here will not report because of the fear of

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W 127	Continued From page 7 retaliation from colleagues on the campus." During interview with RC-Q on 7/28/20, at 9:24 a.m. RC-Q stated, "I worked the evening shift on Saturday 7/18/20, and a double on Sunday 7/19/20...I was shocked when the [DPO] called me last Friday and said I was suspended about a verbal abuse case, I was shocked." RC-Q stated the DPO had told her he could not tell her more but would get back to her soon. RC-Q stated, "I would never do that to the clients. I would never hurt any of them. I have worked here for a long time. I was joking with them that day. [C 9] was taking pictures of me outside. I think I am going to quit my job, it just is not worth risking it. I bet [RC-R] lied and made the clients make this up about me, I know it. [RC-R] gives them what they want!" RC-Q then stated, "I guess I will be contacting the union and letting my other job know, this could wreck my career you know!" RC-Q further stated she was going to school to become a social worker, "This is my passion, I'm worried about that too." RC-Q stated she knows she talks loud but stated she does not yell at the clients or verbally abuse them. During interview 7/28/20, at 11:08 a.m. C10 stated, "[RC-Q] is rude and at times will say 'get the f... (profanity) out of my face.' When she yells I have to cover my ears because it hurts. On the last weekend she worked I saw her hit [C7] on the side of the face with her hand. I heard a smack sound, it was either Saturday or Sunday. I also saw her hit [C7] with a towel. I am afraid of her. On that weekend [C 9] was going to the token cabinet and [RC-Q] yelled at her not to go in there by herself, and pinched her in the shoulder." During interview 7/28/20, at 3:42 p.m. OPD and	W 127		

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W 127	Continued From page 8 the Service Program Director (SPD) stated the staff had been retrained to their Vulnerable Adults policy in March 2020 because they were aware of small sectors of staff being afraid of reporting due an incident a staff reported in February 2020 when a staff member reported on another staff member, and several of the staff then shunned the reporter. They stated they were aware some of the staff would not report due to fear of retaliation, and indicated 4 years ago the facility had a speaker come in to address cultural diversity which was unsuccessful. They also stated they have been trying to get an additional speaker in. The OPD and SPD identified they believed staffs' cultural backgrounds played a role in the divide among staff and their willingness to report on each other. When asked if they had taken measures such as creative scheduling (ensuring staff members of same cultures were not working together) to ensure clients were safe and abuse would be reported or Zero Tolerance Policies for not reporting were in place, etc. they were unable to provide other action that had been taken regarding staff failure to report. A facility policy signed 7/13/20, Reporting of Maltreatment of Vulnerable Adults, indicated under Procedure C: The Facility Must Immediately Report to the appropriate authorities and forward to the Minnesota Adult Abuse Reporting Center (MAARC) abuse including physical, emotional, sexual, psychological, neglect, including mental harm, physical harm, psychological harm, or exploitation regardless of who is the alleged perpetrator. The designee will notify the administrator or administrator designee, collection of all interviews, statements, physical evidence and pertinent, maps, pictures or diagrams, review of all information related to the	W 127		

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W 127	Continued From page 9 allegation and provide initial assessment and action plan as immediate corrective action. The Policy further indicated: Failure to Report 1. A mandated reporter who knows or has reason to believe a vulnerable adult is or has been subject to abuse, neglect, maltreatment, mistreatment, injuries of unknown source, exploitation, involuntary seclusion, and misappropriation of property who fails to report that is found to be serious or recurring may be disqualified from employment in positions allowing direct contact with persons receiving services from programs licensing by the Department of Human Services and by the Minnesota Department of Health. The Immediate Jeopardy was removed on 8/7/20, at 11:45 a.m. when the facility removed the AP from the schedule pending investigation, began an internal investigation, conducted assessment of all clients to ensure safety, and had developed and implemented strategies to ensure their staff would report allegations as required.	W 127		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: The facility failed to thoroughly investigate allegations of abuse for 4 of 4 clients (C7,C8,C9 and C10) who were alleged to be verbally and physically abused by a staff member. Findings include: C7's Profile sheet updated 7/27/20, indicated he	W 154		

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had profound intellectual disability. C7's Individual Abuse Prevention Plan (IAPP) dated 4/16/20, indicated he was susceptible to abuse, and is likely to cooperate in an abusive situation and has inability to be assertive. In addition he would be unable to report incidents of abuse.

C8's Profile sheet updated 7/27/20, indicated he had mild intellectual disability, disability, schizoaffective disorder, adjustment disorder with mixed emotions and conduct, pervasive development disorder. IAPP dated 5/21/20, indicated C8 was susceptible to abuse, inability to identify potentially dangerous situations, may have inappropriate interactions with others which made him vulnerable to abuse, inability to deal with verbally/physically aggressive persons

C9 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). C9'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, 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, inability to deal with verbally/physically aggressive persons.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 08/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 11 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 had 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 items he finds on the floor. The type of slapping that was described resembles cupping [C7's] face with both hands in the same manner from the movie "Home Alone" cups his face after putting after shave on it, and slapping [C7's] face real hard." A facility CEP report dated 7/23/20, indicated C9 had reported that on 7/18/20, RC-Q was mean and yelled at her and housemates a lot when she works. The report further indicated RC-Q had told C9 to go to her room, didn't want C9 to call the supervisor on duty that day, and was loud and bossing residents around. C9's report indicated she helped with meals everyday but RC-Q would not let her, had told her she would get hurt, and told her to get out of the kitchen. The report indicated C9 felt she was being treated like a child. In addition, C9 reported at one point she was told by RC-Q to either go to her room or move out. The report indicated C9 felt afraid of RC-Q, did not want her to return, spent two hours in her room crying, and had "slept all day Sunday" because she did not want to be around RC-Q	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 08/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 12	W 154		

who made her feel bad about herself. C9 also reported she'd witnessed RC-Q hit a resident who was unable to speak for himself with a towel [C7].

A facility reported CEP report dated 7/24/20, indicated C8 reported he feels uncomfortable in his house when RC-Q works and had been told by RC-Q many times that she does not like him and does not want to talk to him. The CEP report indicated when RC-Q had worked the weekend of 7/18/20, C8 had tried to talk to the Director of Operations and RC-Q had said, "Don't follow that dude out." The report indicated when [C8] had tried to explain what he was doing, RC-Q had stated to C8, "I'm done". Further, the report indicated C8 stated RC-Q "treats me real rude and mean, saying she don't like me. When she is scheduled to work I know its going to be a bad weekend." The report further indicated when a housemate had asked RC-Q for the supervisor's phone number, RC-Q yelled at him for that and told him to mind his own business.

During interview with Operations Program Director (OPD) on 7/27/20, at 9:42 a.m. he confirmed two of five interviewable clients in House 1 (where C7 lives) were interviewed regarding the allegations of abuse, stating he did not have time to complete the other interviews with the other clients in the home. Additionally, confirmed he had not interviewed the alleged perpetrator (RC-Q) and only 1 of 2 staff who were working during the alleged abuse. When asked why the investigation was not prioritized, OPD stated there had been so much going on around here, he just did not have time to get to it (the investigation). Furthermore, OPD discussed his interview with RC-R (1 of 2 staff working weekend of alleged abuse) stating RC-R told him she, "will

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	24G208	A. BUILDING _____ B. WING _____	C 08/07/2020

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

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W 154	Continued From page 13	W 154		

not be a whistle blower" and does not want to tell on anyone. RC-R did say she may have heard yelling between RC-Q and another client (C9) but that she was in the laundry room.

Although OPD started his investigation, he confirmed he did not interview all of the clients who had the potential to be affected by the alleged perpetrator (AP). In addition OPD was aware RC-R "will not be a whistle blower" which meant she potentially could have known more about the alleged abuse than what was reported but no further questions were asked. In addition although RC-R admitted she witnessed RC-Q yell at the clients and cup her hands on C7's face, she did not report to the state agency/administrator according to facility policy with no evidence of repercussion from the facility.

A facility policy signed 7/13/20, Reporting of Maltreatment of Vulnerable Adults indicated under Procedure C. The Facility Must Immediately Report to the appropriate authorities and forward to the Minnesota Adult Abuse Reporting Center (MAARC) abuse including physical, emotional, sexual, psychological, neglect, including mental harm, physical harm, psychological harm, or exploitation regardless of who is the alleged perpetrator. The designee will notify the administrator or administrator designee, collection of all interviews, statements, physical evidence and pertinent, maps, pictures or diagrams, review of all information related to the allegation and provide initial assessment and action plan as immediate corrective action. The Policy further indicated Failure to Report 1. A mandated reporter who knows or has reason to believe a vulnerable adult is or has been subject to abuse, neglect, maltreatment, mistreatment,

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

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W 154	Continued From page 14 injuries of unknown source, exploitation, involuntary seclusion, and misappropriation of property who fails to report that is found to be serious or recurring may be disqualified from employment in positions allowing direct contact with persons receiving services from programs licensing by the Department of Human Services and by the Minnesota Department of Health.	W 154		

DEPARTMENT OF HEALTH

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,

Amy Johnson

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00831	A. BUILDING: _____ B. WING _____	C 08/07/2020

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

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 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).	5 000		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
24G208	A. BUILDING _____ B. WING _____	7/27/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility failed to identify interventions likely to reduce behavioral incidents in an attempt to keep vulnerable clients in the home safe and reduce aggressive behavioral symptoms for 1 of 3 clients (C2) reviewed for abuse. The facility failed to provide adequate assessment and supervision for 1 of 1 clients (C5) reviewed who was at risk for elopement. approved Received 9/28/20 10/7/20	W122	Corrective measures have been completed and documented for C2 and C5 in the IJ removal plans which were approved on 7/10/2020 and 7/4/2020. The facility will following corrective action when other residents have the potential to be affected by the same deficient practice: After a resident to resident aggression occurs, the following actions will take place. A. Immediate action by staff 1. Staff will respond to the degree necessary to ensure the safety of all parties involved. 2. Staff monitored visually to safeguard the resident and remained available to provide physical guidance, if needed, to ensure the two Residents are separated. 3. Staff provided reminders of earned incentives of better choices, redirected to appropriate activities, and avoided responses which would reinforce the behavior. 4. Staff monitored both residence and their whereabouts and interactions until threat or risk of further altercations has ceased and increase supervision as needed B. Assess and monitor the victim 1. Staff assessed for evidence of a physical injury and contacted nursing as necessary. Any injury and care provided is noted on the incident report. 2. Staff will support the victim to engage in their normal routine, provided emotional support as needed, and protect them from further retaliation. Victim is monitored for signs of developing of psychological and physical harm. Any signs are noted in POR and QIDP/Nursing is contacted 3. Incident is logged in the victims POR's to monitor for any changes that would indicate harm to the Resident.	9/10/2020

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	9/10/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	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 for 1 of 3 clients (C2) reviewed for abuse. The facility failed to provide adequate assessment and supervision for 1 of 1 clients (C5) reviewed who was at risk for elopement.	W122	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. 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.	9/10/2020

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[signature]	Administrator	9/10/20

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		A. BUILDING _____ B. WING _____	7/27/2020

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

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	Based on interview and record review the facility failed to inform a legal guardian/parent of client safety concerns and obtain permission prior to moving a client from House 2 to House 7 on the facility's campus for 1 of 1 clients (C5) reviewed for rights.	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. 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: 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 emergency. 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 administrator. 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 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 assist in preparing for movement, unless an emergency (medical) situation prevents that involvement. 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 9/10/2020.	9/10/2020

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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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
24G208	A. BUILDING _____ B. WING _____	7/27/2020

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

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	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. plan ~~should~~ include C1, assessment, care plan ~~revisions~~ and training of staff on ~~changes~~ to plan addendum added as attached approved	W127 ~~rejected~~	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 Maltreatment 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 reminding of the requirement for mandatory 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 completion so tracking can be done. Completion Date: 7/31/20 for loading memo into L&D Center. 8/6/20 for staff completion. Those not 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	8/6/2020

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LABORATORY DIRECTOR'S OR ~~PROVIDER/SUPPLIER~~ REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9/10/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	7/27/2020

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

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	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 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. 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. Completion Date: 8/3/20	8/6/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Based on interview and document review, the facility failed to thoroughly investigate allegations of abuse for 1 of 1 client (C1) reviewed for staff to client abuse. The facility further failed to thoroughly investigate client to client abuse for 2 of 3 residents (C7 & C8) reviewed for client to client abuse.	W149 approved	Based on the review of this area of concern, the following plan of correction has been completed: On 8/3/2020 , program supervisors were retrained by the services director on the requirement of immediate reporting suspected abuse 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 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'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, maltreatment, mistreatment, injuries of unknown source, exploitation, involuntary seclusion, 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	8/6/2020

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9/10/20

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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24G208	A. BUILDING _____ B. WING _____	7/27/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on interview and document review, the facility failed to ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.	w153 approved	Based on the review of this area of concern, the following plan of correction has been completed: On 8/3/2020 , program supervisors were retrained by the services director on the requirement of immediate reporting suspected abuse. 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 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'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, maltreatment, mistreatment, injuries of unknown source, exploitation, involuntary seclusion, 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	8/6/2020

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9/10/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	7/27/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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.	W247	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. 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 a resident move, the affected resident will be given an explanation 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.	9/10/2020

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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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
24G208	A. BUILDING _____ B. WING _____	7/27/2020

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

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	Based on interview and document review, the facility failed to update, revise or change financial programs for 2 of 4 clients (C3 and C2) reviewed in the sample who went off campus to implement their money management programs.	257 approved	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.	9/20/20

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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Lake Owasso Residence	210 N. Owasso Blvd., Shoreview, MN 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 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. 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. 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.	9/10/2020

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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24G208	A. BUILDING _____ B. WING _____	7/27/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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. approved	371	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.	9/20/20

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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

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

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	Based on interview and document review the facility failed to ensure that personnel on all shifts were trained to perform assigned tasks during evacuation drills. approved	W442	Based on the review of this area of concern, the following is the plan of correction: The Emergency and Special Procedures Training was completed by all staff on 8/6/2020. The services director is responsible for monitoring completion of trainings to ensure sustained adherence to time lines in the Orientation and Training Policy. 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 language: "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 duties, life safety procedures and the fire protection devices in their assigned area. i. Facility fire drills will be suspended upon assessment of increased risk by the director of nursing." Supervisors will be provided retraining on continuous monitoring of fire drill procedures and practices by the services director by 9/10/2020. The operations director is responsible for monitoring the application of fire drills in the facility.	9/10/2020

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[signature]	Administrator	9/10/20

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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24G208	A. BUILDING _____ B. WING _____	7/27/2020

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

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	Base on observations, interview and document review, failed to ensure all staff were wearing protective personal equipment (PPE) eye protection for 2 of 2 houses (houses 4 and 5) observed. approved	W455	Based on the review of this area of concern, the following is the plan of correction: A COVID-19 Response Policy was authored on 6/23/2020 and provided to employees for training. This policy did include the following guidelines which address the concerns noted in the CMS-2567. At the time of the survey, staff were out of compliance to the policy. 7/28/2020: Language was added to include goggles. Each staff was notified of the goggle requirement at the beginning of their next shift during the entrance screening. See Section II: B.5 "Staff are always required to wear a face 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 8/3/2020. 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 continue to monitor, document, and address concerns with PPE compliance.	9/10/2020

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[signature]	Administrator	9/10/20

DEPARTMENT OF HEALTH

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,

Amy Johnson

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	R-C 11/03/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS An onsite revisit was conducted on 11/2/20 and 11/3/20, to determine compliance with federal deficiencies issued during a full survey exited on 7/27/20. The facility was determined to have not met substantial compliance with the regulations at 42 CFR 483. Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Condition of Participation at 42 CFR 483.420 Client Protection, was found to be back in compliance with only standard deficiencies reissued.	{W 000}		
{W 153}	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to immediately report client to client abuse for 1 of 5 clients (C9) reviewed for abuse. Findings included: C9's Profile sheet updated 6/22/20, indicated she had diagnosis of moderate intellectual disability and bipolar. An Incident Report Form (IRF) dated 10/25/20, at 2:50 p.m. indicated C9 was getting her laundry	{W 153}		

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

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	24G208	A. BUILDING _____ B. WING _____	R-C 11/03/2020

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

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{W 153}	Continued From page 1	{W 153}		

while yelling. C9 then stubbed her toe and started screaming and swearing. A housemate then backed her into a wall and scratched her and pulled her hair. Staff immediately separated them and provided redirection to both clients. Staff continued to observe the clients and helped keep them apart for the rest of the evening with redirection to maintain the safety of themselves and others. C9 sustained minor injury to her face that included a scratch and a bloody lip from self-injurious behavior (SIB). The report indicated the nurse was called. Staff cleansed her lip, Aquaphor was applied and ice. No report was made to the state agency (SA) at the time.

Records indicated on 10/26/20, at 9:51 a.m. director of operations (DO) submitted a report to the SA.

During an interview on 11/3/20, at 12:09 p.m. DO stated after an incident, the nurse assesses the client injuries and does what is needed. The nurse then fills out the IRF and gives to the supervisor. The DO stated there was no supervisor onsite that evening and the nurse did not submit a report to the SA. The DO stated all staff are trained to report to the SA. The DO stated there was a supervisor on call until Monday morning that could have been called to submit a report to the SA.

At 12:15 p.m. the DO stated this incident should have been reported sooner than Monday morning when I came in and saw it on the desk. The DO stated it should have been reported after the incident occurred. The DO stated we have had issues in the past with reporting. When asked, DO identified the nurse involved had not been formally disciplined or retrained to date.

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LAKE OWASSO RESIDENCE	**210 OWASSO BLVD NORTH SHOREVIEW, MN 55126**

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{W 153}	Continued From page 2 The facility policy Reporting of Maltreatment of Vulnerable Adults revision date 9/30/20, revealed A. 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. B. Allegation includes abuse neglect, maltreatment, mistreatment, injuries of unknown source, exploitation, involuntary seclusion, and misappropriation of property, a report to the SA is required. Reporting made by the facility must be done immediately to the appropriate authorities. C. The facility must immediately report: 11. Resident to resident altercations which are willful, the action(s) result in infliction of injury, unreasonable, confinement, intimidation or punishment with likelihood of resulting physical harm, pain, or mental anguish.	{W 153}		
{W 455}	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by:	{W 455}		