DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email on April 1, 2021

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

RE: Event ID: J3UL11

Dear Administrator:

On March 23, 2021, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. At the time of the survey, the survey team noted one or more deficiencies.

Federal certification deficiencies are delineated on the electonically delivered 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:

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

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

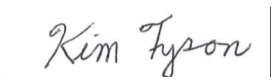
Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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

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

Sincerely,



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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed on April 1, 2021

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

Re: Project Number Event ID: J3UL11

Dear Administrator:

The above facility survey was completed on March 23, 2021 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56.

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,

Kim Tyson

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00831	A. BUILDING: _____ B. WING _____	C 03/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 3/23/21, surveyors of this Department's staff visited the above provider. Lake Owasso is in full compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following were found substantiated with no citations: HG208102C / MN71079 HG208103C / MN71093 HG208104C / MN71067	5 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00831	A. BUILDING: _____ B. WING _____	C 03/23/2021

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	Continued From page 1 The following was found unsubstantiated: HG208105C / MN71028	5 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 03/23/2021

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

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W 000	INITIAL COMMENTS On 3/23/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was NOT IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following were found substantiated with no citations: HG208102C / MN71079 HG208103C / MN71093 HG208104C / MN71067 The following was found unsubstantiated: HG208105C / MN71028 However, as a result of the investigation a deficiency was identified at W154.	W 000		
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: Based on interview and document review, the facility failed to complete a thorough investigation regarding alleged sexual abuse for 1 of 3 clients (C3) reviewed for abuse. Findings include: C3's profile sheet, undated, indicated an admission date of 9/11/01. C3 had diagnoses which included mild intellectual disability, total blindness, post-traumatic stress disorder, and	W 154		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 03/23/2021

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 1 major depressive disorder. C3's individual abuse prevention plan (IAPP) dated 9/3/20, indicated C3 was susceptible to sexual abuse and lacked understanding of sexuality, was likely to seek/cooperate in an abusive situation and had the inability to be assertive. Additionally, C3 was at risk of sexual abuse from others. C3 would be unable to physically defend herself from the sexual aggression of others and would not be able to recognize situations where she is at risk of sexual exploitation. C3 would not be able to defend herself due to naiveté or desire to please, against the unwanted sexual advances of others. C4's profile sheet, undated, indicated an admission date of 5/3/18. C4 had diagnoses which included disruptive disorder and moderate intellectual disability. C4's IAPP dated 5/18/20, indicated C4 was susceptible to sexual abuse and lacked understanding of sexuality, was likely to seek/cooperate in an abusive situation and had the inability to be assertive. Further, C4 had poor understanding of boundaries with others and would not have understood the meaning of safe sex practices, consent and when/where it was appropriate to touch people. C4 could repeat to staff what consent and appropriate touch was but in the moment C4 was not able to follow these rules. C4 may make inappropriate comments towards male and female staff, housemates, and peers in the community. Staff have reported that C4 would touch female staff's arms and hair without their consent and in a manner that sometimes made them feel uncomfortable.	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 03/23/2021

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 2	W 154		

Facility incident report dated 3/17/21, indicated C3 reported to facility staff that C4 kissed her on the cheeks, inappropriately touched her neck and shoulder area and made inappropriate comments to her in the hallway such as "squishy boobies" or about wanting to have sex. C3 stated it made her uncomfortable. C3 reported to facility staff she told C4 she doesn't like this. The report also indicated C3 had a history of sexual abuse. C3 had reported this was not the first time it had occurred. C3 and C4 had a history of being boyfriend and girlfriend, however, at the time of the report C3 stated they were not. Additionally, the report indicated C3 had a history of exaggerating stories and false reporting. Following the allegation, the house supervisor (HS)-A instructed staff to increase supervision and ensure C3 and C4 were not alone together. HS-A was also going to get C3 a key so she could lock her door. The investigation lacked interview with C4.

During interview on 3/23/21, at 8:41 a.m. residential counselor (RC)-A stated there was an incident reported about a week ago between C3 and C4. RC-A stated staff had to make sure they were not alone together. RC-A stated C4 was interested in girls, needed redirection when he had been inappropriate and was typically responsive to redirection. RC-A stated C4 required frequent reminders to respect the body space between him and other staff members and clients.

During interview on 3/23/21, at 9:15 a.m. C3 stated that C4 had kissed her and they were not boyfriend and girlfriend. C3 stated she was going to get a key for her door and had not wanted anyone in her room. C3 would not elaborate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 03/23/2021

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 3 more with surveyor. During interview on 3/23/21, at 11:27 house supervisor (HS)-A stated she had interviewed C3 after being made aware of the above incident. HS-A stated sometimes she interviewed other clients that resided in the same house as part of a thorough investigation and in this case had not because it might have upset the other clients. HS-A stated had not interviewed C4 yet. During interview on 3/23/21, at 1:36 p.m. RC-C stated C4 had a history of saying inappropriate things to C3. RC-C stated they would redirect him and it had been part of the program plan to identify and redirect behaviors. During interview on 3/23/21, at 2:19 p.m. C4 stated he had kissed C3 before but had asked her first. C4 also denied inappropriate comments directed toward C3. During interview on 3/23/21, at 3:15 p.m. program director (PD) stated C4 should have been interviewed sooner as part of a thorough investigation. PD stated had not thought it would be necessary to interview the other house members to ensure they felt safe. Facility policy "Reporting of Maltreatment of Vulnerable Adults" dated 9/30/20, indicated the facility would have maintained evidence that all alleged violations were thoroughly investigated and would have prevented further potential abuse while the investigation was in progress. The designee would have collected all interviews and statements as part of their duties.	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 _____	6/2/2020

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 complete a thorough investigation regarding alleged sexual abuse for 1 of 3 clients (C3) reviewed for abuse.	154	Based on the review of this area of concern, the following is the plan of correction: On 4/1/2021 the program supervisors and operations director were provided retraining on completions of thorough internal investigation. The training focused on the following areas: 1. The completion of interviews with relevant witnesses and other residents who may be impacted by the incident or perpetrator or to determine what, if anything, happened and to determine the complete, factual circumstances surrounding the alleged incident. 2. Action must be taken to prevent further potential abuse while the investigation is in progress. Administrator is responsible for oversight of implementation of the correction order. The operations director will be responsible for completion of internal investigation with the direct supervision of the administrator. The completed internal investigations will be audited monthly by the quality assurance designee to ensure the effectiveness of the plan of correction.	4/1/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See 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	4/12/2021

INSTRUCTIONS FOR COMPLETION OF THE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

I. **PURPOSE**
This document contains a listing of deficiencies cited by the surveying State Agency (SA) or Regional Office (RO) as requiring correction. The Summary Statement of Deficiencies is based on the surveyors' professional knowledge and interpretation of Medicare and/or Medicaid or Clinical Laboratory Improvement Amendments requirements.

II. **FORM COMPLETION**
Name and Address of Facility – Indicate the name and address of the facility identified on the official certification record. When surveying multiple sites under one identification number, identify the site where a deficiency exists in the text of the deficiency under the Summary Statement of Deficiencies column.

Prefix Identification Tag – Each cited deficiency and corrective action should be preceded by the prefix identification tag (as shown to the left of the regulation in the State Operations Manual or survey report form). For example, a deficiency in Patient Test Management (493.1107) would be preceded by the appropriate D-Tag in the 3000 series. A deficiency cited in the Life Safety Code provision 2-1 (construction) would be preceded by K8. Place this appropriate identification tag in the column labeled ID Prefix Tag.

III. **Summary Statement of Deficiencies** – Each cited deficiency should be followed by full identifying information, e.g., 493.1107(a). Each Life Safety Code deficiency should be followed by the referenced citation from the Life Safety Code and the provision number shown on the survey report form.

IV. **Plan of Correction** – In the column Plan of Correction, the statements should reflect the facility's plan for corrective action and the anticipated time of correction (an explicit date must be shown). If the action has been completed when the form is returned, the plan should indicate the date completed. The date indicated for completion of the corrective action must be appropriate to the level of the deficiency(ies).

V. **Waivers** – Waivers of other than Life Safety Code deficiencies in hospitals are by regulations specifically restricted to the RN waiver as provided in section 1861(e)(5) of the Social Security Act. The long term care regulations provide for waiver of the regulations for nursing, patient room size and number of beds per room. The regulations provide for variance of the number of beds per room for intermediate care facilities for the mentally retarded. Any other deficiency must be covered by an acceptable plan of correction. The waiver principle cannot be invoked in any other area than specified by regulation.

VI. **Waiver Asterisk(*)** – The footnote pertaining to the marking by asterisk of recommended waivers presumes an understanding that the use of waivers is specifically restricted to the regulatory items. In any event, when the asterisk is used after a deficiency statement, the CMS Regional Office should indicate in the right hand column opposite the deficiency whether or not the recommended waiver has been accepted.

VII. **Signature** – This form should be signed and dated by the provider or supplier representative or the laboratory director. The original, with the facility's proposed corrective action, must be returned to the appropriate surveying agency (SA or RO) within 10 days of receipt. Please maintain a copy for your records.