DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

December 9, 2021

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

RE: Event ID: 2KPE11

Dear Administrator:

On November 22, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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
	24G208	A. BUILDING _____ B. WING _____	C 11/22/2021

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 000	INITIAL COMMENTS Susie Haven On 11/22/21, 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 complaints were found to be SUBSTANTIATED: HG208176C (MN00078548 & MN00078594), with a deficiency cited at W331. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	W 000	received 12/20/21 approved 12/21/21 POC 12/30/21 Based up the noted citation: • The nursing supervisor has been retrained by the administrator of the requirement to respond in a timely manner to all medical concerns reported, conducts assessments as indicated, and monitor resident progress following illness or injury. The direct care will be retrained on the requirement to be responsive to health care needs or injuries of residents. The training will include: o incidents must be verbally reported to the on-duty program supervisor and on-duty nursing immediately for assessment of injury. o Leaving a voicemail is not enough; the initial reporter must speak to the on-duty program supervisor and the on-duty nurse. o The initial reporter will document the incident on an “Accident/Incident Report Form” and submit to an on-duty administrator designee. • The "Lake Owasso Nursing Schedule" has been reformatted to provide clear directions on who to contact when a nurse is not on campus. LOR is also purchasing an additional cell phone for on-call nurses to take home.	12/30/21
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure clients received prompt nursing services and treatment after a fall for 1 of 1 clients (C1) resulting in a shoulder dislocation. Findings include: C1's functioned at a level of mild intellectual disability. C1's Coordinated Services and Support Plan Self Management Assessment, dated 3/24/21, indicated C1 walked independently with an unsteady gait and does not always focus on where she is walking and the type of ground she is on. C1 had broke her arm in the past after	W 331		

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

12/15/2021

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 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.

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W 331	Continued From page 1 a fall and at risk for breaking bones from a fall. C1's accident/incident report dated 11/14/21, C1 had self reported to staff she had slipped on ice getting her newspaper. Nursing assessment indicated two messages from the house where C1 resides was left at 9:30 a.m. on 11/14/21. No nurse was on the ground at that time of call. Bruise starting on right wrist going into palm of C1's hand. Unable to complete range of motion on the rise side of arm. No bruises on upper arm, no swelling at the time, no open areas. C1 was unable to lift arm up or out to the side. C1 stated it hurts, had difficulty getting out of a chair and unable to assess any further per C1 request. C1 stated staff were informed of the fall and staff left a message at the nurses office. C1 stated her pain was managed with Tylenol that was given until nurses assessment was completed. Records indicated C1 fell at 8:30 a.m. and nurse assessment was completed at 1:05 p.m. Facility failed to follow procedure to call the on-call management when a nurse is not on-site. When interviewed on 11/22/21, at 12:40 p.m. direct support staff (DSS)-A stated a phone call was placed and message was left at the nurses office approximately 8:30 a.m. DSS-A stated the nurse did not come to assess C1 until noon the same day as the incident. When interviewed on 11/22/21, at 4:08 p.m. licensed practical nurse (LPN) stated staff left a message on the nurses office voicemail and did not call the on-call manager as this is the protocol. LPN stated she did not come to the facility until 11:25 a.m. and the message was left around 8:45 a.m. LPN stated C1 was assessed after message was received and on-site.	W 331	• Lake Owasso administrator designee's will be responsible for ensuring direct care staff adhere to reporting procedures daily. • Nursing supervisor is responsible for implementation of the correction order. • The administrator is responsible for oversight of policies and procedures related to nursing services	

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W 331	Continued From page 2 When interviewed on 11/22/21, at 4:32 p.m. registered nurse (RN) stated staff did not follow protocol and did not call the on-call manager. RN stated he was on-call that day of this incident and did not receive a call. RN confirmed C1 waited approximately 4 hours for a nurse to assess.	W 331		

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December 9, 2021

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

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: 2KPE11

Dear Administrator:

The above facility was surveyed on November 22, 2021 through November 22, 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 one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the first page of the order form should be signed and returned to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susie Haben. A written plan for correction of licensing orders is not required.

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.

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

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W 000	INITIAL COMMENTS On 11/22/21, 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 complaints were found to be SUBSTANTIATED: HG208176C (MN00078548 & MN00078594), with a deficiency cited at W331. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	W 000		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure clients received prompt nursing services and treatment after a fall for 1 of 1 clients (C1) resulting in a shoulder dislocation. Findings include: C1's functioned at a level of mild intellectual disability. C1's Coordinated Services and Support Plan Self Management Assessment, dated 3/24/21, indicated C1 walked independently with an unsteady gait and does not always focus on where she is walking and the type of ground she is on. C1 had broke her arm in the past after	W 331		

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W 331	Continued From page 2 When interviewed on 11/22/21, at 4:32 p.m. registered nurse (RN) stated staff did not follow protocol and did not call the on-call manager. RN stated he was on-call that day of this incident and did not receive a call. RN confirmed C1 waited approximately 4 hours for a nurse to assess.	W 331		

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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 11/22/21, a complaint investigation was conducted. Your facility was found to be not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaints were found to be SUBSTANTIATED: HG208176C (MN00078548 & MN00078594), with an order cited at 0380 .	5 000		

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5 000	Continued From page 1 When corrections are completed, please sign and date, make a copy of these orders and electronically return to: susie.haben@state.mn.us	5 000		
5 380	MN Rule 4665.3300 PURPOSE OF HEALTH SERVICES. Health services shall be utilized to maintain an optimal general level of health and to maximize function, prevent disability, and promote optimal development of each resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure clients received prompt nursing services and treatment after a fall for 1 of 1 clients (C1) resulting in a shoulder dislocation. Findings include: C1's functioned at a level of mild intellectual disability. C1's Coordinated Services and Support Plan Self Management Assessment, dated 3/24/21, indicated C1 walked independently with an unsteady gait and does not always focus on where she is walking and the type of ground she is on. C1 had broke her arm in the past after a fall and at risk for breaking bones from a fall. C1's accident/incident report dated 11/14/21, C1 had self reported to staff she had slipped on ice getting her newspaper. Nursing assessment indicated two messages from the house where C1 resides was left at 9:30 a.m. on 11/14/21. No	5 380		

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5 380	Continued From page 2	5 380		

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When interviewed on 11/22/21, at 12:40 p.m. direct support staff (DSS)-A stated a phone call was placed and message was left at the nurses office approximately 8:30 a.m. DSS-A stated the nurse did not come to assess C1 until noon the same day as the incident.

When interviewed on 11/22/21, at 4:08 p.m. licensed practical nurse (LPN) stated staff left a message on the nurses office voicemail and did not call the on-call manager as this is the protocol. LPN stated she did not come to the facility until 11:25 a.m. and the message was left around 8:45 a.m. LPN stated C1 was assessed after message was received and on-site.

When interviewed on 11/22/21, at 4:32 p.m. registered nurse (RN) stated staff did not follow protocol and did not call the on-call manager. RN stated he was on-call that day of this incident and did not receive a call. RN confirmed C1 waited approximately 4 hours for a nurse to assess.

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5 380	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 380		