DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

April 13, 2022

Administrator
Preferred Residential Lifestyles-Hcl Inc
108 Ninth Street
Windom, MN 56101

RE: Event ID: X2PO11

Dear Administrator:

On March 30, 2022, 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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
	24G244	A. BUILDING _____ B. WING _____	C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED RESIDENTIAL LIFESTYLES-HCL INC	**108 NINTH STREET WINDOM, MN 56101**

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W 000	INITIAL COMMENTS On 3/29/22 and 3/30/22, 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 with no deficiencies cited. HG244021C (MN81673) HG244022C (MN81773) HG244023C (MN81772) HG244024C (MN81771) HG244025C (MN81770) HG244026C (MN81769) HG244027C (MN80935) However as a result of the investigation, deficiencies were cited at W149, W153 and W155. 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		

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.

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W 000	Continued From page 1	W 000		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to implement abuse policies and procedures consistent with federal regulations by not reporting to the State Agency (SA) and administrator immediately for alleged verbal abuse for 1 of 1 client (C1) and neglect of care (supervision) for 5 of 6 clients (C2, C3, C4, C5, C6) reviewed for allegations of abuse/neglect. The facility further failed to ensure staff completed required training following an episode of neglect for 5 of 6 clients (C2, C3, C4, C5, C6) reviewed for neglect. Findings include: Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B	W 149		

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W 149	Continued From page 2	W 149		

reported an allegation of abuse to program director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an ... [profanity used]". DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report the allegation to anyone until 3 days later, and DSP-B continued to provide direct care for C1. The PD reported the allegation to the administrator on 3/8/22, at 1:05 p.m. The administrator submitted the allegation of abuse to the SA at that time.

Interview on 3/30/22, at 9:00 a.m. a.m. the facility AD confirmed the above allegation of abuse towards C1, had not been reported to the administrator or the SA immediately, per facility policy. The facility AD indicated all staff are trained on abuse upon hire and annually. Review of the VA report submitted to the SA on 3/11/22, at 4:20 p.m. indicated DSP-D was found asleep on 3/10/22, at 4:20 p.m.. The shift she was working was an awake shift and the individuals in the apartment (C2, C3, C4, C5, C6) required awake supervision.

The facility Incident Report dated 3/11/22, indicated on 3/10/22, it was reported that licensed practical nurse (LPN)-A discovered DSP-D asleep in the recliner in the living room. The individuals (C2, C3, C4, C5, C6) required awake supervision. This was an awake shift.

The Mentor Network Report Form for Internal

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W 149	Continued From page 3 Investigation printed 3/29/22, indicated C2's Individual Abuse Prevention Plan (IAPP) dated 4/2021, included C2 required 24 hour awake supervision and support person on premises at all times when individual was home. C3's IAPP dated 7/2021, indicated C3 could be unsupervised in the home for zero minutes and support person on premises at all times when individual was at home. C4's IAPP dated 5/2021, indicated C4 can be unsupervised in the home for zero minutes. C5's IAPP dated 11/2021, indicated C5 can be unsupervised in the home for zero minutes. C6's IAPP dated 6/2021, indicated C6 required 24 hour awake supervision and if a staff person from apartment 4 needed to run an errand such as making copies downstairs, etc. Staff would make C6 aware that they were leaving the apartment as C6 was able to use his buzzer if he needed something. The double door to apartment 3 must be opened and staff from apartment 3 made aware they needed to check on C6. The internal investigation further indicated DSP-D had confirmed falling asleep in apartment 4, and further confirmed knowledge that it was an awake shift. The internal investigation also included interview with LPN-A and the program director (PD). Program director had indicated being in apartment 4 on 3/10/22, shortly before 4:00 a.m. and DSP-D was awake. LPN-A had entered apartment 4 on 3/10/22, at 4:20 p.m. and found DSP-D asleep. The internal investigation indicated DSP-D would complete her assigned maltreatment training by 3/21/22, and would review and acknowledge C2, C3, C4, C5, and C6's RISK plan (IAPP) by 3/21/22. On 3/29/22, at 11:40 a.m. LPN-A confirmed entering apartment 4 on 3/10/22, at 4:20 p.m. and found DSP-D asleep in the living room reclined in	W 149		

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W 149	Continued From page 4	W 149		

one of the client's chairs. LPN-A awakened DSP-D and reminded her she wasn't to be using the client's personal recliners. LPN-A stated leaving for the day shortly after that; she went home and thought about the incident and reported it to her supervisor the next day. When asked why LPN-A didn't report the incident immediately she indicated all the supervisory staff had already left for the day. LPN-A confirmed she probably should have called her supervisor immediately after the incident occurred.

On 3/29/22, at 1:03 p.m. quality improvement specialist (QIS)-A confirmed staff should be reporting any allegation of abuse/neglect to their supervisor immediately. QIS-A confirmed she would have expected LPN-A to report the the incident on 3/10/22, to a supervisor immediately rather than waiting until the next day.

On 3/29/22, at 3:00 p.m. DSP-D confirmed she had been working by herself on 3/10/22, in apartment 4 as someone had called in sick. DSP-D stated she was sitting in one of the client recliners and became too comfortable. DSP-D confirmed she had drifted off to sleep about 15-20 minutes DSP-D stated she had no training following the incident, though the regional director had talked with her about the incident.

On 3/30/22, at 10:16 a.m. QIS-A stated program supervisor (PS)-A or the program director (PD)-A would be responsible to ensure DSP-D completed the training requirements following the incident. QIS-A stated she would follow up to see if training was completed. At 10:31 a.m., QIS-A confirmed there was no documentation indicating DSP-D had completed the required training following the incident on 3/10/22.

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W 149	Continued From page 5 The facility's policy Vulnerable Adult revised on 8/20/18, included gestured language towards a vulnerable adult, degrading remarks, use of repeated malicious oral, written or derogatory, humiliating , harassing, or threatening language as abuse towards a vulnerable adult. The policy directed facility staff to report suspected instances of abuse, neglect or financial exploitation internally or externally. These instances should be immediately reported to the PD or area director (AD). Mandated reporters are to make an initial report and remain responsible for seeing that their report reaches the appropriate external agency. The fallibility staff also have the option to directly report any of these allegations to the Minnesota Adult Abuse Reporting Center (MAARC). The investigating team will conduct the investigation including: g. If applicable, the company will develop, document and implement a corrective action plan designed to prevent current lapses and prevent future lapses in performance.	W 149		
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 alleged verbal abuse for 1 of 1 client (C1) and neglect of care (supervision) for 5 of 6 clients (C2, C3, C4, C5, C6) to the administrator and designated State	W 153		

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W 153	Continued From page 6 Agency (SA) for clients reviewed for allegations of abuse/neglect. Findings include: Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B reported an allegation of abuse to program director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an ... [profanity used]". DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report the allegation to anyone until 3 days later, and DSP-B continued to provide direct care for C1. The PD reported the allegation to the administrator on 3/8/22, at 1:05 p.m. The administrator submitted the allegation of abuse to the SA at that time. Interview on 3/30/22, at 9:00 a.m. a.m. the facility AD confirmed the above allegation of abuse towards C1, had not been reported to the administrator or the SA immediately, per facility policy. The facility AD indicated all staff are trained on abuse upon hire and annually. Review of the VA report submitted to the SA on 3/11/22, at 4:20 p.m. indicated DSP-D was found asleep on 3/10/22, at 4:20 p.m.. The shift she was working was an awake shift and the individuals in the apartment (C2, C3, C4, C5, C6) required awake supervision.	W 153		

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W 153	Continued From page 7 The facility Incident Report dated 3/11/22, indicated on 3/10/22, it was reported that licensed practical nurse (LPN)-A discovered DSP-D asleep in the recliner in the living room. The individuals (C2, C3, C4, C5, C6) required awake supervision. This was an awake shift. On 3/29/22, at 11:40 a.m. LPN-A confirmed entering apartment 4 on 3/10/22, at 4:20 p.m. and found DSP-D asleep in the living room reclined in one of the client's chairs. LPN-A awakened DSP-D and reminded her she wasn't to be using the client's personal recliners. LPN-A stated leaving for the day shortly after that; she went home and thought about the incident and reported it to her supervisor the next day. When asked why LPN-A didn't report the incident immediately she indicated all the supervisory staff had already left for the day. LPN-A confirmed she probably should have called her supervisor immediately after the incident occurred. On 3/29/22, at 1:03 p.m. quality improvement specialist (QIS)-A confirmed staff should be reporting any allegation of abuse/neglect to their supervisor immediately. QIS-A confirmed she would have expected LPN-A to report the the incident on 3/10/22, to a supervisor immediately rather than waiting until the next day. The facility's policy Vulnerable Adult revised on 8/20/18, included gestured language towards a vulnerable adult, degrading remarks, use of repeated malicious oral, written or derogatory, humiliating , harassing, or threatening language as abuse towards a vulnerable adult. The policy directed facility staff to report suspected instances of abuse, neglect or financial exploitation internally or externally. These	W 153		

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W 153	Continued From page 8 instances should be immediately reported to the PD or area director (AD). Mandated reporters are to make an initial report and remain responsible for seeing that their report reaches the appropriate external agency. The fallibility staff also have the option to directly report any of these allegations to the Minnesota Adult Abuse Reporting Center (MAARC).	W 153		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure clients protection and safety were provided for 1 of 1 client (C1), when a facility staff person witnessed another staff being verbally abusive towards clients. This had the potential to affect all clients residing in apartment 3. Findings include: C1's information cover sheet (undated), identified diagnoses including profound intellectual disability, cerebral palsy, cortical blindness and neuromuscular scoliosis. C1's individual abuse risk assessment (RA) dated 4/13/21, identified C1 as presenting a risk of not being able to get himself out of an abusive situation, and would likely not understand that he is being abused. The assessment also identified C1 as not being able to remove himself from a abusive situation. The RA further included that all staff are mandated reporters and would immediately report observed and/or suspected	W 155		

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W 155	Continued From page 9 incidents of abuse. Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B reported an allegation of abuse to program director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an ... [profanity used]." DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report the allegation to anyone until 3 days later, and DSP-B continued to provide direct care for C1. Review of an internal investigation dated 3/8/22 through 3/10/22 indicated through interview with the facility PD on 3/8/22, DSP-B reported to her on 3/7/22, at 7:00 p.m. that she had heard DSP-A telling C1 that he was an ... .(profanity used). Interview with DSP-B on 3/8/22, indicated she assisted DSP-A with toileting C1 on 3/8/22, at around 4:00 p.m.. DSP-B indicated while they were changing C1's brief, DSP-A called C1 an ... (profanity used). Around 20 minutes later DSP-B stated C1, C8 and C9 were in the kitchen, when DSP-A again called C1 an (profanity used) in front of C8 and C9. When assisting C9 to bed that evening, she proceeded to blurt out same profanity. DSP-A told C9 to "quit repeating what I say" During the investigation DSP-B was asked if there were other incidents of verbal abuse,when DSP-B indicated a while ago (no time date given) DSP-A told C10 to "shut up" because she had been screaming. DSP-A also called C10 "fat".	W 155		

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The investigative report indicated DSP-A was placed on suspension when the administrator was informed on 3/8/22, at 1:05 p.m. The investigative report indicated there was no need for additional staff training and policies and procedures were implemented. The report further indicated the plan of action taken would be the facility AD would work with Human Relations (HR) regarding a plan of action for DSP-A of which may be termination of employment. The investigative report did not include re-educating the facility staff for timely reporting of abuse nor did it included what had been done to protect C1 and all other clients from abuse when DSP-B witnessed verbal abuse towards C1 and C10.

Review of the staffing schedule from 3/4/22 to 3/8/22, indicated DSP-A worked on 3/4/22, from 1:00 p.m. to 9:00 p.m. and DSP-B from 2:00 p.m. to 10:00 p.m. DSP-A was scheduled to work on 3/7/22, but called in ill.

Review of the most current staff education on abuse/maltreatment for DSP-A, DSP-B and the facility PD, indicated DSP-A received training on 1/29/22, DSP-B on 1/27/22 and the facility PD on 1/22/22.

Interview on 3/29/22, at 2:00 p.m. DSP-B, confirmed the above abuse allegations towards C1. DSP-B indicated she had witnessed several incidents since 9/21, that DSP-B had been verbally abusive towards a client. DSP-A also confirmed DSP-B continued to finish her work shift after she had witnessed verbal abuse towards C1 and C10 (4 hours). DSP-B stated she did not report the verbal abuse until 3 days later, when the facility PD asked her to fill in an open shift. DSP-B stated she did not want to work the

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(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 155	Continued From page 11	W 155		

open shift because she would have had to work with DSP-A, and she is mean. DSP-A further indicated she had been trained on abuse in the past year, and did not realize allegations of abuse needed to be reported to management immediately. DSP-B also confirmed she had witnessed DSP-A being verbally abusive towards C10 and other clients in the past several months. DSP-B confirmed she had not been re-educated on abuse since the allegation occurred.

Interview on 3/29/22, at 1:30 p.m. facility PD confirmed she had been aware of the allegations of abuse towards C1, when it came up in a conversation with DSP-B on 3/7/22, at 7:00. The PD indicated she asked DSP-B to fill in an open shift, but refused because she did not want to work with DSP-A because she was mean. At that time, DSP-B informed the PD of the allegation of DSP's-A verbal abuse towards C1. The PD indicated she did not report the allegation to the administrator until the 3/8/22 (the following day) in the am. The PD indicated she thought she had 24 hours to report the allegations to administration and the SA, even though she had been recently educated on abuse. The PD confirmed she had not been re-educated on abuse since the allegation occurred.

Interview on 3/30/22, at 10:00 a.m. facility quality improvement specialist (QIS) indicated she conducted the internal investigation and confirmed the above findings. The QIS indicated she will recommend a plan of action after the investigation and forward this to the facility AD. The QIS verified she did not recommend re-education on abuse and timely reporting for the PD or DSP-B. The QIS indicated she did not recommend the training because both employees

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G244	A. BUILDING _____ B. WING _____	C 03/30/2022

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PREFERRED RESIDENTIAL LIFESTYLES-HCL INC	108 NINTH STREET WINDOM, MN 56101

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W 155	Continued From page 12 had just received the training prior to the allegation and did not think it was then needed. Interview on 3/29/22 at 10:30 a.m. the facility AD confirmed the above findings of the allegation of abuse towards C1. The AD also confirmed staff re-education on abuse had not been done, and allegations of abuse should be reported immediately to the administrator and the SA, but had not been. The AD indicated all staff had been recently been trained on abuse. DSP-B confirmed she did not report the incident of allegations of abuse towards C1 immediately to management and should have. DSP-B stated she received training on abuse upon hire and annually, but failed to follow the policy. DSP-B verified DSP-A continued to work her shift (total of 6 hours) after the incident was observed. Interview on 4/28/21, at 2:30 p.m. the executive director (ED) indicated all staff are trained on abuse. The ED further indicated she would have expected the staff to follow facility policy and report the above allegations of abuse immediately, to the administrator and SA. The facility's policy Vulnerable Adult revised on 8/20/18, included abuse as being gestured language towards a vulnerable adult, degrading remarks, use of repeated malicious oral, written or derogatory, humiliating , harassing, or threatening language. The policy directed facility staff to report suspected instances of abuse, neglect or financial exploitation internally or externally. These instances should be immediately reported to the PD or area director (AD). Mandated reporters are to make an initial report and remain responsible for seeing that	W 155		

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W 155	Continued From page 13 their report reaches the appropriate external agency. The fallibility staff also have the option to directly report any of these allegations to the Minnesota Adult Abuse Reporting Center (MAARC).	W 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01194	A. BUILDING: _____ B. WING _____	C 03/30/2022

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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 3/29/22 and 3/30/22, 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: HG244021C (MN81673) HG244022C (MN81773) HG244023C (MN81772)	5 000		

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5 000	Continued From page 1 HG244024C (MN81771) HG244025C (MN81770) HG244026C (MN81769) HG244027C (MN80935) However, as a result of the invesitgation, related licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and electronically return to: Elizabeth Silkey elizabeth.silkey@state.mn.us	5 000		
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above.	5 815		

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5 815	Continued From page 2 (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report alleged verbal abuse for 1 of 1 client (C1) and neglect of care (supervision) for 5 of 6 clients (C2, C3, C4, C5, C6) to the designated State Agency (SA) for clients reviewed for allegations of abuse/neglect. Findings include: Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B reported an allegation of abuse to program	5 815		

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5 815	Continued From page 3 director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an ... [profanity used]". DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report the allegation to anyone until 3 days later, and DSP-B continued to provide direct care for C1. The PD reported the allegation to the administrator on 3/8/22, at 1:05 p.m. The administrator submitted the allegation of abuse to the SA at that time. Interview on 3/30/22, at 9:00 a.m. a.m. the facility AD confirmed the above allegation of abuse towards C1, had not been reported to the administrator or the SA immediately, per facility policy. The facility AD indicated all staff are trained on abuse upon hire and annually. Review of the VA report submitted to the SA on 3/11/22, at 4:20 p.m. indicated DSP-D was found asleep on 3/10/22, at 4:20 p.m.. The shift she was working was an awake shift and the individuals in the apartment (C2, C3, C4, C5, C6) required awake supervision. The facility Incident Report dated 3/11/22, indicated on 3/10/22, it was reported that licensed practical nurse (LPN)-A discovered DSP-D asleep in the recliner in the living room. The individuals (C2, C3, C4, C5, C6) required awake supervision. This was an awake shift. On 3/29/22, at 11:40 a.m. LPN-A confirmed entering apartment 4 on 3/10/22, at 4:20 p.m. and	5 815		

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5 815	Continued From page 4	5 815		

found DSP-D asleep in the living room reclined in one of the client's chairs. LPN-A awakened DSP-D and reminded her she wasn't to be using the client's personal recliners. LPN-A stated leaving for the day shortly after that; she went home and thought about the incident and reported it to her supervisor the next day. When asked why LPN-A didn't report the incident immediately she indicated all the supervisory staff had already left for the day. LPN-A confirmed she probably should have called her supervisor immediately after the incident occurred.

On 3/29/22, at 1:03 p.m. quality improvement specialist (QIS)-A confirmed staff should be reporting any allegation of abuse/neglect to their supervisor immediately. QIS-A confirmed she would have expected LPN-A to report the the incident on 3/10/22, to a supervisor immediately rather than waiting until the next day.

The facility's policy Vulnerable Adult revised on 8/20/18, included gestured language towards a vulnerable adult, degrading remarks, use of repeated malicious oral, written or derogatory, humiliating , harassing, or threatening language as abuse towards a vulnerable adult. The policy directed facility staff to report suspected instances of abuse, neglect or financial exploitation internally or externally. These instances should be immediately reported to the PD or area director (AD). Mandated reporters are to make an initial report and remain responsible for seeing that their report reaches the appropriate external agency. The fallibility staff also have the option to directly report any of these allegations to the Minnesota Adult Abuse Reporting Center (MAARC).

TIME PERIOD FOR CORRECTION: Twenty one

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5 815	Continued From page 5 (21) days.	5 815		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 13, 2022

Administrator
Preferred Residential Lifestyles-HCL Inc
108 Ninth Street
Windom, MN 56101

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: X2PO11

Dear Administrator:

The above facility was surveyed on March 29, 2022 through March 30, 2022 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 Elizabeth Silkey. 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 3/29/22 and 3/30/22, 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 with no deficiencies cited. HG244021C (MN81673) HG244022C (MN81773) HG244023C (MN81772) HG244024C (MN81771) HG244025C (MN81770) HG244026C (MN81769) HG244027C (MN80935) However as a result of the investigation, deficiencies were cited at W149, W153 and W155. 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	POC Received- 4-18-22 POC Approved- 5-20-22 Liz Silkey	

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

Jessie Markus | Regional Director | 4/18/22

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 000	Continued From page 1	W 000		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to implement abuse policies and procedures consistent with federal regulations by not reporting to the State Agency (SA) and administrator immediately for alleged verbal abuse for 1 of 1 client (C1) and neglect of care (supervision) for 5 of 6 clients (C2, C3, C4, C5, C6) reviewed for allegations of abuse/neglect. The facility further failed to ensure staff completed required training following an episode of neglect for 5 of 6 clients (C2, C3, C4, C5, C6) reviewed for neglect. Findings include: Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B	W 149	**W 149** **To rectify the immediate need:** The program will implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client. All staff will be retrained on the requirement to report all abuse/neglect immediately to the administrator/ supervisor and state agency. **Ongoing:** All incidents of potential allegations of abuse/neglect will be reported immediately to the designated state agency. Annually all staff will be retrained on Policy 12.1 (Administrative Review of Incidents) and their responsibilities to report immediately. Staff will complete and document all required training following any episode of neglect/abuse. **Monitoring:** The corrections will be implemented by the QIDP/Program Director and monitored by the Area Director. Reporting timeliness and training needs/completion (documentation) will be audited following all episodes of neglect/abuse. **Completion Date:** 5/4/22	

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W 149	Continued From page 2 reported an allegation of abuse to program director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an ... [profanity used]". DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report the allegation to anyone until 3 days later, and DSP-B continued to provide direct care for C1. The PD reported the allegation to the administrator on 3/8/22, at 1:05 p.m. The administrator submitted the allegation of abuse to the SA at that time. Interview on 3/30/22, at 9:00 a.m. a.m. the facility AD confirmed the above allegation of abuse towards C1, had not been reported to the administrator or the SA immediately, per facility policy. The facility AD indicated all staff are trained on abuse upon hire and annually. Review of the VA report submitted to the SA on 3/11/22, at 4:20 p.m. indicated DSP-D was found asleep on 3/10/22, at 4:20 p.m.. The shift she was working was an awake shift and the individuals in the apartment (C2, C3, C4, C5, C6) required awake supervision. The facility Incident Report dated 3/11/22, indicated on 3/10/22, it was reported that licensed practical nurse (LPN)-A discovered DSP-D asleep in the recliner in the living room. The individuals (C2, C3, C4, C5, C6) required awake supervision. This was an awake shift. The Mentor Network Report Form for Internal	W 149		

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PREFERRED RESIDENTIAL LIFESTYLES-HCL INC	108 NINTH STREET WINDOM, MN 56101

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W 149	Continued From page 3 Investigation printed 3/29/22, indicated C2's Individual Abuse Prevention Plan (IAPP) dated 4/2021, included C2 required 24 hour awake supervision and support person on premises at all times when individual was home. C3's IAPP dated 7/2021, indicated C3 could be unsupervised in the home for zero minutes and support person on premises at all times when individual was at home. C4's IAPP dated 5/2021, indicated C4 can be unsupervised in the home for zero minutes. C5's IAPP dated 11/2021, indicated C5 can be unsupervised in the home for zero minutes. C6's IAPP dated 6/2021, indicated C6 required 24 hour awake supervision and if a staff person from apartment 4 needed to run an errand such as making copies downstairs, etc. Staff would make C6 aware that they were leaving the apartment as C6 was able to use his buzzer if he needed something. The double door to apartment 3 must be opened and staff from apartment 3 made aware they needed to check on C6. The internal investigation further indicated DSP-D had confirmed falling asleep in apartment 4, and further confirmed knowledge that it was an awake shift. The internal investigation also included interview with LPN-A and the program director (PD). Program director had indicated being in apartment 4 on 3/10/22, shortly before 4:00 a.m. and DSP-D was awake. LPN-A had entered apartment 4 on 3/10/22, at 4:20 p.m. and found DSP-D asleep. The internal investigation indicated DSP-D would complete her assigned maltreatment training by 3/21/22, and would review and acknowledge C2, C3, C4, C5, and C6's RISK plan (IAPP) by 3/21/22. On 3/29/22, at 11:40 a.m. LPN-A confirmed entering apartment 4 on 3/10/22, at 4:20 p.m. and found DSP-D asleep in the living room reclined in	W 149		

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	24G244	A. BUILDING _____ B. WING _____	C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED RESIDENTIAL LIFESTYLES-HCL INC	108 NINTH STREET WINDOM, MN 56101

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W 149	Continued From page 4 one of the client's chairs. LPN-A awakened DSP-D and reminded her she wasn't to be using the client's personal recliners. LPN-A stated leaving for the day shortly after that; she went home and thought about the incident and reported it to her supervisor the next day. When asked why LPN-A didn't report the incident immediately she indicated all the supervisory staff had already left for the day. LPN-A confirmed she probably should have called her supervisor immediately after the incident occurred. On 3/29/22, at 1:03 p.m. quality improvement specialist (QIS)-A confirmed staff should be reporting any allegation of abuse/neglect to their supervisor immediately. QIS-A confirmed she would have expected LPN-A to report the the incident on 3/10/22, to a supervisor immediately rather than waiting until the next day. On 3/29/22, at 3:00 p.m. DSP-D confirmed she had been working by herself on 3/10/22, in apartment 4 as someone had called in sick. DSP-D stated she was sitting in one of the client recliners and became too comfortable. DSP-D confirmed she had drifted off to sleep about 15-20 minutes DSP-D stated she had no training following the incident, though the regional director had talked with her about the incident. On 3/30/22, at 10:16 a.m. QIS-A stated program supervisor (PS)-A or the program director (PD)-A would be responsible to ensure DSP-D completed the training requirements following the incident. QIS-A stated she would follow up to see if training was completed. At 10:31 a.m., QIS-A confirmed there was no documentation indicating DSP-D had completed the required training following the incident on 3/10/22.	W 149		

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W 149	Continued From page 5 The facility's policy Vulnerable Adult revised on 8/20/18, included gestured language towards a vulnerable adult, degrading remarks, use of repeated malicious oral, written or derogatory, humiliating , harassing, or threatening language as abuse towards a vulnerable adult. The policy directed facility staff to report suspected instances of abuse, neglect or financial exploitation internally or externally. These instances should be immediately reported to the PD or area director (AD). Mandated reporters are to make an initial report and remain responsible for seeing that their report reaches the appropriate external agency. The fallibility staff also have the option to directly report any of these allegations to the Minnesota Adult Abuse Reporting Center (MAARC). The investigating team will conduct the investigation including: g. If applicable, the company will develop, document and implement a corrective action plan designed to prevent current lapses and prevent future lapses in performance.	W 149		
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 alleged verbal abuse for 1 of 1 client (C1) and neglect of care (supervision) for 5 of 6 clients (C2, C3, C4, C5, C6) to the administrator and designated State	W 153		

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W 153	Continued From page 6 Agency (SA) for clients reviewed for allegations of abuse/neglect. Findings include: Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B reported an allegation of abuse to program director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an ... [profanity used]". DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report the allegation to anyone until 3 days later, and DSP-B continued to provide direct care for C1. The PD reported the allegation to the administrator on 3/8/22, at 1:05 p.m. The administrator submitted the allegation of abuse to the SA at that time. Interview on 3/30/22, at 9:00 a.m. a.m. the facility AD confirmed the above allegation of abuse towards C1, had not been reported to the administrator or the SA immediately, per facility policy. The facility AD indicated all staff are trained on abuse upon hire and annually. Review of the VA report submitted to the SA on 3/11/22, at 4:20 p.m. indicated DSP-D was found asleep on 3/10/22, at 4:20 p.m.. The shift she was working was an awake shift and the individuals in the apartment (C2, C3, C4, C5, C6) required awake supervision.	W 153	**W 153** **To rectify immediate need:** All staff will be retrained on Policy 12.1 (Administrative Notification of Incidents) and their responsibilities in regards to reporting all potential allegations of abuse/neglect immediately to the administrator. **Ongoing:** The program will ensure that all allegations of maltreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator and to the state agency in accordance with State law through established procedures. **Monitoring:** The corrections will be implemented by the QIDP/Program Director and monitored by the Area Director. Reporting timeliness will be audited following all episodes of neglect/abuse. **Completion Date:** 5/4/22	

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W 153	Continued From page 7 The facility Incident Report dated 3/11/22, indicated on 3/10/22, it was reported that licensed practical nurse (LPN)-A discovered DSP-D asleep in the recliner in the living room. The individuals (C2, C3, C4, C5, C6) required awake supervision. This was an awake shift. On 3/29/22, at 11:40 a.m. LPN-A confirmed entering apartment 4 on 3/10/22, at 4:20 p.m. and found DSP-D asleep in the living room reclined in one of the client's chairs. LPN-A awakened DSP-D and reminded her she wasn't to be using the client's personal recliners. LPN-A stated leaving for the day shortly after that; she went home and thought about the incident and reported it to her supervisor the next day. When asked why LPN-A didn't report the incident immediately she indicated all the supervisory staff had already left for the day. LPN-A confirmed she probably should have called her supervisor immediately after the incident occurred. On 3/29/22, at 1:03 p.m. quality improvement specialist (QIS)-A confirmed staff should be reporting any allegation of abuse/neglect to their supervisor immediately. QIS-A confirmed she would have expected LPN-A to report the the incident on 3/10/22, to a supervisor immediately rather than waiting until the next day. The facility's policy Vulnerable Adult revised on 8/20/18, included gestured language towards a vulnerable adult, degrading remarks, use of repeated malicious oral, written or derogatory, humiliating , harassing, or threatening language as abuse towards a vulnerable adult. The policy directed facility staff to report suspected instances of abuse, neglect or financial exploitation internally or externally. These	W 153		

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W 153	Continued From page 8 instances should be immediately reported to the PD or area director (AD). Mandated reporters are to make an initial report and remain responsible for seeing that their report reaches the appropriate external agency. The fallibility staff also have the option to directly report any of these allegations to the Minnesota Adult Abuse Reporting Center (MAARC).	W 153		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure clients protection and safety were provided for 1 of 1 client (C1), when a facility staff person witnessed another staff being verbally abusive towards clients. This had the potential to affect all clients residing in apartment 3. Findings include: C1's information cover sheet (undated), identified diagnoses including profound intellectual disability, cerebral palsy, cortical blindness and neuromuscular scoliosis. C1's individual abuse risk assessment (RA) dated 4/13/21, identified C1 as presenting a risk of not being able to get himself out of an abusive situation, and would likely not understand that he is being abused. The assessment also identified C1 as not being able to remove himself from a abusive situation. The RA further included that all staff are mandated reporters and would immediately report observed and/or suspected	W 155		

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W 155	Continued From page 9 incidents of abuse. Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B reported an allegation of abuse to program director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an ... [profanity used]." DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report the allegation to anyone until 3 days later, and DSP-B continued to provide direct care for C1. Review of an internal investigation dated 3/8/22 through 3/10/22 indicated through interview with the facility PD on 3/8/22, DSP-B reported to her on 3/7/22, at 7:00 p.m. that she had heard DSP-A telling C1 that he was an ... .(profanity used). Interview with DSP-B on 3/8/22, indicated she assisted DSP-A with toileting C1 on 3/8/22, at around 4:00 p.m.. DSP-B indicated while they were changing C1's brief, DSP-A called C1 an ... (profanity used). Around 20 minutes later DSP-B stated C1, C8 and C9 were in the kitchen, when DSP-A again called C1 an (profanity used) in front of C8 and C9. When assisting C9 to bed that evening, she proceeded to blurt out same profanity. DSP-A told C9 to "quit repeating what I say" During the investigation DSP-B was asked if there were other incidents of verbal abuse, when DSP-B indicated a while ago (no time date given) DSP-A told C10 to "shut up" because she had been screaming. DSP-A also called C10 "fat".	W 155	**W155** **To rectify immediate need:** All staff will be retrained on the requirement to provide immediate protection and safety to all clients (including C1) when a episode of abuse/maltreatment has been identified. **Ongoing:** The facility will ensure actions are immediately taken to prevent further potential abuse while the investigation is in progress. **Monitoring:** The corrections will be implemented by the QIDP/Program Director and will be monitored by the Area Director. Steps taken to protect the individual will be audited following all episodes of neglect/abuse to ensure there will be no further abuse while the investigation is in progress. **Completion Date:** 6/13/22	

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W 155	Continued From page 10	W 155		

The investigative report indicated DSP-A was placed on suspension when the administrator was informed on 3/8/22, at 1:05 p.m. The investigative report indicated there was no need for additional staff training and policies and procedures were implemented. The report further indicated the plan of action taken would be the facility AD would work with Human Relations (HR) regarding a plan of action for DSP-A of which may be termination of employment. The investigative report did not include re-educating the facility staff for timely reporting of abuse nor did it included what had been done to protect C1 and all other clients from abuse when DSP-B witnessed verbal abuse towards C1 and C10.

Review of the staffing schedule from 3/4/22 to 3/8/22, indicated DSP-A worked on 3/4/22, from 1:00 p.m. to 9:00 p.m. and DSP-B from 2:00 p.m. to 10:00 p.m. DSP-A was scheduled to work on 3/7/22, but called in ill.

Review of the most current staff education on abuse/ maltreatment for DSP-A, DSP-B and the facility PD, indicated DSP-A received training on 1/29/22, DSP-B on 1/27/22 and the facility PD on 1/22/22.

Interview on 3/29/22, at 2:00 p.m. DSP-B, confirmed the above abuse allegations towards C1. DSP-B indicated she had witnessed several incidents since 9/21, that DSP-B had been verbally abusive towards a client. DSP-A also confirmed DSP-B continued to finish her work shift after she had witnessed verbal abuse towards C1 and C10 (4 hours). DSP-B stated she did not report the verbal abuse until 3 days later, when the facility PD asked her to fill in an open shift. DSP-B stated she did not want to work the

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W 155	Continued From page 11 open shift because she would have had to work with DSP-A, and she is mean. DSP-A further indicated she had been trained on abuse in the past year, and did not realize allegations of abuse needed to be reported to management immediately. DSP-B also confirmed she had witnessed DSP-A being verbally abusive towards C10 and other clients in the past several months. DSP-B confirmed she had not been re-educated on abuse since the allegation occurred. Interview on 3/29/22, at 1:30 p.m. facility PD confirmed she had been aware of the allegations of abuse towards C1, when it came up in a conversation with DSP-B on 3/7/22, at 7:00. The PD indicated she asked DSP-B to fill in an open shift, but refused because she did not want to work with DSP-A because she was mean. At that time, DSP-B informed the PD of the allegation of DSP's-A verbal abuse towards C1. The PD indicated she did not report the allegation to the administrator until the 3/8/22 (the following day) in the am. The PD indicated she thought she had 24 hours to report the allegations to administration and the SA, even though she had been recently educated on abuse. The PD confirmed she had not been re-educated on abuse since the allegation occurred. Interview on 3/30/22, at 10:00 a.m. facility quality improvement specialist (QIS) indicated she conducted the internal investigation and confirmed the above findings. The QIS indicated she will recommend a plan of action after the investigation and forward this to the facility AD. The QIS verified she did not recommend re-education on abuse and timely reporting for the PD or DSP-B. The QIS indicated she did not recommend the training because both employees	W 155		

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W 155	Continued From page 12 had just received the training prior to the allegation and did not think it was then needed. Interview on 3/29/22 at 10:30 a.m. the facility AD confirmed the above findings of the allegation of abuse towards C1. The AD also confirmed staff re-education on abuse had not been done, and allegations of abuse should be reported immediately to the administrator and the SA, but had not been. The AD indicated all staff had been recently been trained on abuse. DSP-B confirmed she did not report the incident of allegations of abuse towards C1 immediately to management and should have. DSP-B stated she received training on abuse upon hire and annually, but failed to follow the policy. DSP-B verified DSP-Acontinued to work her shift (total of 6 hours) after the incident was observed. Interview on 4/28/21, at 2:30 p.m. the executive director (ED) indicated all staff are trained on abuse. The ED further indicated she would have expected the staff to follow facility policy and report the above allegations of abuse immediately, to the administrator and SA. The facility's policy Vulnerable Adult revised on 8/20/18, included abuse as being gestured language towards a vulnerable adult, degrading remarks, use of repeated malicious oral, written or derogatory, humiliating , harassing, or threatening language. The policy directed facility staff to report suspected instances of abuse, neglect or financial exploitation internally or externally. These instances should be immediately reported to the PD or area director (AD). Mandated reporters are to make an initial report and remain responsible for seeing that	W 155		

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W 155	Continued From page 13 their report reaches the appropriate external agency. The fallibility staff also have the option to directly report any of these allegations to the Minnesota Adult Abuse Reporting Center (MAARC).	W 155		

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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 3/29/22 and 3/30/22, 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: HG244021C (MN81673) HG244022C (MN81773) HG244023C (MN81772)	5 000	Signed lic orders received- 4/18/22 Liz Silkey	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jessie Markus — Regional Director — 4/18/22

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5 000	Continued From page 1 HG244024C (MN81771) HG244025C (MN81770) HG244026C (MN81769) HG244027C (MN80935) However, as a result of the invesitgation, related licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and electronically return to: Elizabeth Silkey elizabeth.silkey@state.mn.us	5 000		
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above.	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01194	A. BUILDING: _____ B. WING _____	C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED RESIDENTIAL LIFESTYLES-HCL	108 NINTH STREET WINDOM, MN 56101

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5 815	Continued From page 2 (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report alleged verbal abuse for 1 of 1 client (C1) and neglect of care (supervision) for 5 of 6 clients (C2, C3, C4, C5, C6) to the designated State Agency (SA) for clients reviewed for allegations of abuse/neglect. Findings include: Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B reported an allegation of abuse to program	5 815		

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5 815	Continued From page 3 director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an ... [profanity used]". DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report the allegation to anyone until 3 days later, and DSP-B continued to provide direct care for C1. The PD reported the allegation to the administrator on 3/8/22, at 1:05 p.m. The administrator submitted the allegation of abuse to the SA at that time. Interview on 3/30/22, at 9:00 a.m. a.m. the facility AD confirmed the above allegation of abuse towards C1, had not been reported to the administrator or the SA immediately, per facility policy. The facility AD indicated all staff are trained on abuse upon hire and annually. Review of the VA report submitted to the SA on 3/11/22, at 4:20 p.m. indicated DSP-D was found asleep on 3/10/22, at 4:20 p.m.. The shift she was working was an awake shift and the individuals in the apartment (C2, C3, C4, C5, C6) required awake supervision. The facility Incident Report dated 3/11/22, indicated on 3/10/22, it was reported that licensed practical nurse (LPN)-A discovered DSP-D asleep in the recliner in the living room. The individuals (C2, C3, C4, C5, C6) required awake supervision. This was an awake shift. On 3/29/22, at 11:40 a.m. LPN-A confirmed entering apartment 4 on 3/10/22, at 4:20 p.m. and	5 815		

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5 815	Continued From page 4 found DSP-D asleep in the living room reclined in one of the client's chairs. LPN-A awakened DSP-D and reminded her she wasn't to be using the client's personal recliners. LPN-A stated leaving for the day shortly after that; she went home and thought about the incident and reported it to her supervisor the next day. When asked why LPN-A didn't report the incident immediately she indicated all the supervisory staff had already left for the day. LPN-A confirmed she probably should have called her supervisor immediately after the incident occurred. On 3/29/22, at 1:03 p.m. quality improvement specialist (QIS)-A confirmed staff should be reporting any allegation of abuse/neglect to their supervisor immediately. QIS-A confirmed she would have expected LPN-A to report the the incident on 3/10/22, to a supervisor immediately rather than waiting until the next day. The facility's policy Vulnerable Adult revised on 8/20/18, included gestured language towards a vulnerable adult, degrading remarks, use of repeated malicious oral, written or derogatory, humiliating , harassing, or threatening language as abuse towards a vulnerable adult. The policy directed facility staff to report suspected instances of abuse, neglect or financial exploitation internally or externally. These instances should be immediately reported to the PD or area director (AD). Mandated reporters are to make an initial report and remain responsible for seeing that their report reaches the appropriate external agency. The fallibility staff also have the option to directly report any of these allegations to the Minnesota Adult Abuse Reporting Center (MAARC). TIME PERIOD FOR CORRECTION: Twenty one	5 815		

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5 815	Continued From page 5 (21) days.	5 815		