Electronically Delivered Via Email on June 4, 2021

Administrator
Res Advantages Inc Luverne
107 South Blue Mound Avenue
Luverne, MN 56156

RE: Event ID: Z5OM11

Dear Administrator:

On May 12, 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:

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, MN 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

POC recieved 7-2-21
POC rejected 8-1-21
POC Rebmitted 8-3-21
POC Approved 8-4-21
Liz Silkey

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

PRINTED: 06/04/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G330	A. BUILDING _____ B. WING _____	C 05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES ADVANTAGES INC LUVERNE	107 SOUTH BLUE MOUND AVENUE LUVERNE, MN 56156

(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 On 5/11/21 through 5/12/21, 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 complaint was found to be substniated: HG330004C (MN72471), however NO deficieninceis were cited due to actions implemented by facility prior to survey.	W 000	**W 149** The program will implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client. All incidents of potential allegations of abuse/neglect will be reported immediately to the designated state, with the subsequent investigation of all potential allegations of abuse/ neglect to be completed within 5 days. All staff will be retrained on the Policy (Administrative Notification of Incidents) and their responsibilities in regards to reporting all potential allegations of abuse/neglect immediately to the administrator and the regulatory agency. All corrections will be implemented by the QIDP and monitored by the Area Director. The facility will audit VA reports for a period of 6 months to ensure reporting is being done according to policy and procedure. **Completion Date:6/9/21**	
W 149	However, as a result of the investigation deficiencies were identified at W149 and W153 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 that directed staff to immediately report alleged client to client abuse to State Agency (SA), for 3 of 3 clients (C1, C2, C4) who were reviewed for client altercations involving suspected or actual physical abuse. Findings include: Review of facility Incident Report dated 12/16/20, at 3:25 p.m., indicated when the program supervisor (PS) was coming from the north side	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessie Markus
TITLE: Regional Director
(X6) DATE: 8/3/21

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 149	Continued From page 1	W 149		

of the home to where C2 was in the south side living room, PS heard C4, who had been sitting in a recliner in the living room say "no" to C2. As the PS came around the corner, the PS witnessed C2 bent over in front of C4 in the recliner. The PS observed C2 reaching for something and C4 saying "no". As the PS started to redirect C2, C2 came at PS and pushed PS just past the Christmas tree, pulled on the PS's shirt sleeve, kicked the Christmas tree, looked at the PS then went and slapped C4 in the stomach. PS redirected C2 who then sat down in a recliner and put his head in his hands. The Incident Report indicated C4 sustained a bruise from being hit by C2. The PS completed Incident Report, verbally notified the program director, and notified the guardian and case manager by email on 12/16/20. The facility's quality improvement committee was notified by email on 12/16/20, and had reviewed the incident report on 12/18/20. The facility failed to identify a report was made to the SA.

Review of facility Incident Report dated 12/28/20 at 7:30 p.m., identified C2 entered C1's room while the door was closed and started to take a DVD (digital movie) that was not his. When C1 told C2 it was his, C2 hit C1 in the chest leaving a red mark. The Incident Report indicated when staff checked on C2 in his bedroom, C2 looked mad so the staff left C2 alone. The staff told C2 they would get him a snack in a little bit. A short time later C2 went to the kitchen, went around the counter and came striking at staff. When the staff blocked themselves from C2's hits, C2 fell to floor. Staff put their hands out to keep him from getting up as there was another client sitting at the table. C2 grabbed the vacuum that was close by and swung it next to the other client almost

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W 149	Continued From page 2 hitting them. C2 then knocked everything off the table, pulled the Christmas tree down, threw it and just laid on the floor. External parties notified were identified as C2's guardian and case worker by email and C1's guardian verbally, all on 12/28/20. The PS who filled out the incident report also notified the facility's quality improvement committee via email, and the incident report was reviewed on 12/29/20. The report failed to identify a report was made to the SA. Review of facility Incident Report dated 4/7/21 at 6:30 p.m., indicated staff walked into the hallway and saw C2 entering his room and slamming the door. Staff spoke to C1 who reported that C2 had gone into C1's room when he was out of the room, and had taken one of C1's movies. When C1 tried to take the movie back from C2, C2 hit C1 with a closed fist on the right side of his head and on his back with the bedroom door. Staff checked for injuries and C1 had red marks on his right side and on his left side of his back. Staff contacted the PS and C1's guardian of the incident. The PS completed the incident form, notified the facility's quality improvement committee via email, had notified the program director, the area director, C2's guardian and C1's guardian verbally all on 4/7/21. The quality improvement manager reviewed the incident report on 4/8/21. Review of the facility report to the SA submitted 4/8/21 at 10:19 a.m., identified the incident occurred on 4/7/21 at 6:36 p.m., the report indicated C1 was the Vulnerable Adult (VA), and the Alleged Perpetrator (AP) was C2. The allegation indicated C2 went into the C1's room and was attempting to take his movie. C2 hit C1	W 149		

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W 149	Continued From page 3 with a closed fist on the right side of his back. C2 then went into his bedroom, slammed the door, and stayed there until he calmed down. The incident was not reported tot he SA until the the day after the incident. During interview on 5/11/21 at 11:59 a.m., direct support professional (DSP)-A identified when there is a client to client altercation, the first person they contact is the PS. DSP-A said if staff were unable to get a hold of the PS, staff would call the nurse. DSP-A was unsure who the PS notified. DSP-A revealed that the PS was the one to contact the families of the involved clients, and was the one who completed an incident report speaking to staff and reviewing their staff notes. During interview on 5/11/21 at 12:40 p.m., licensed practical nurse (LPN)-A identified all client to client altercations are reported to the PS. LPN-A revealed she was unaware of who was responsible for submitting a report to the SA as she had no part of that process. During interview on 5/12/21 at 2:06 p.m., with the PS identified when she reported a client to client altercation she notifies the program director (PD), then fills out the incident report by talking to staff and clients, and then reviews the progress notes and notifies the quality improvement staff of the incident. The PS revealed the quality improvement (QI) staff reviewed all incidents reports to determine whether a SA report needed to be submitted, and then completed the investigation. If we are notified by QI that a SA report needs to be made then the PD or area director (AD) would file that report. Interview on 5/12/21 at 4:19 p.m., with program	W 149		

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W 149	Continued From page 4 director (PD) identified that the QI management makes the decisions if an event is reportable. She revealed that the PS notified her and the QI staff via an email when an incident occurred at which time the QI would then review the incident and lets her know if SA report needed to be filed. The QI staff completed all investigations. She confirmed if a client had been slapped or hit that there should have been a SA report filed. Interview on 5/13/21 at 9:32 a.m., with quality improvement staff identified she reviewed all incident reports and followed the Vulnerable Adult policy for reporting to the SA system. She confirmed she had missed reporting on some of the facilities first incidents involving C2, C1, and C4. Her understanding of the policy was that the facility had 24 hours to make a SA report for any type of incident however, she revealed the Minnesota Department of Health identified it was to be made immediately, confirming that immediate was vague to her. She confirmed she had been following the Vulnerable Adult policy and reporting within 24 hours. Review of the 8/20/18, Administrative Review of Incidents policy identified physical abuse as slapping, hitting, pinching, punching, or kicking by which bodily harm or trauma occurs. The policy identified any suspected or actual abuse will be reported immediately to the state Designated Reporting Agency and complaints/allegations and thoroughly investigated. Review of the 8/20/18, Vulnerable Adult policy identified adults receiving services will be protected from maltreatment. The policy identified abuse non accidental hitting, slapping, pinching, kicking, biting, or corporal punishment. Staff are	W 149		

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W 149	Continued From page 5 to report immediately to the Program Director or Area Director. All allegations of suspected or actual abuse will be reported to MAARC (SA) within 24 hours of initial knowledge.	W 149	**W 153** The program will 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. All incidents of potential allegations of abuse/neglect will be reported immediately to the administrator. All staff will be retrained on the Policy (Administrative Notification of Incidents) and their responsibilities in regards to reporting all potential allegations of abuse/neglect immediately to the administrator. The corrections will be implemented by the QIDP and monitored by the Area Director. The facility will audit VA reports for a period of 6 months to ensure reporting is being done according to policy and procedure. **Completion Date:6/9/21**	
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 allegation of client to client abuse to the designated State Agency (SA) for 3 of 3 client (C1, C2, C4) reviewed for allegations of physical abuse. Findings include: Review of facility Incident Report dated 12/16/20, at 3:25 p.m., indicated when the program supervisor (PS) was coming from the north side of the home to where C2 was in the south side living room, the PS heard C4, who had been sitting in a recliner in the living room say "no" to C2. As the PS came around the corner, the PS witnessed C2 bent over in front of C4 in the recliner. The PS observed C2 reaching for something and C4 saying "no". As the PS started to redirect C2, C2 came at PS and pushed PS just past the Christmas tree, pulled on the PS's shirt sleeve, kicked the Christmas tree, looked at the PS then went and slapped C4 in the stomach.	W 153		

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

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W 153	Continued From page 6 PS redirected C2 who then sat down in a recliner and put his head in his hands. The Incident Report indicated C4 sustained a bruise from being hit by C2. The PS completed an Incident Report, verbally notified the program director, and notified the guardian and case manager by email on 12/16/20. The facility's quality improvement committee was notified by email on 12/16/20, and had reviewed the incident report on 12/18/20. The report failed to identify a repot was made to state agency. Review of facility Incident Report dated 12/28/20 at 7:30 p.m., identified C2 entered C1's room while the door was closed and started to take a DVD (digital movie) that was not his. When C1 told C2 it was his, C2 hit C1 in the chest leaving a red mark. The Incident Report indicated when staff checked on C2 in his bedroom, C2 looked mad so the staff left C2 alone. The staff told C2 they would get him a snack in a little bit. A short time later C2 went to the kitchen, went around the counter and came striking at staff. When the staff blocked themselves from C2's hits, C2 fell to floor. Staff put their hands out to keep him from getting up as there was another client sitting at the table. C2 grabbed the vacuum that was close by and swung it next to the other client almost hitting them. C2 then knocked everything off the table, pulled the Christmas tree down, threw it and just laid on the floor. External parties notified were identified as C2's guardian and case worker by email and C1's guardian verbally, all on 12/28/20. The PS who filled out the incident report also notified the facility's quality improvement committee via email, and the incident report was reviewed on 12/29/20. The report failed to identify a report was made to the SA.	W 153		

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W 153	Continued From page 7 Review of facility Incident Report dated 4/7/21 at 6:30 p.m., indicated staff walked into the hallway and saw C2 entering his room and slamming the door. Staff spoke to C1 who reported that C2 had gone into C1's room when he was out of the room, and had taken one of C1's movies. When C1 tried to take the movie back from C2, C2 hit C1 with a closed fist on the right side of his head and on his back with the bedroom door. Staff checked for injuries and C1 had red marks on his right side and on his left side of his back. Staff contacted the PS and C1's guardian of the incident. The PS completed the incident form, notified the facility's quality improvement committee via email, had notified the program director, the area director, C2's guardian and C1's guardian verbally all on 4/7/21. The quality improvement manager reviewed the incident report on 4/8/21. The report failed to identify a report was made to the SA. Review of the facility's report to the SA submitted 4/8/21 at 10:19 a.m., identified the above incident occurred on 4/7/21 at 6:36 p.m., the report indicated C1 was the Vulnerable Adult (VA), and the Alleged Perpetrator (AP) was C2. The allegation indicated C2 went into the C1's room and was attempting to take his movie. C2 hit C1 with a closed fist on the right side of his back. C2 then went into his bedroom, slammed the door, and stayed there until he calmed down. The report had been filed the day after the incident.	W 153		
	During interview on 5/11/21 at 11:59 a.m., direct support professional (DSP)-A stated when there is a client to client altercation, the first person they contact is the PS. DSP-A said if staff were unable to get a hold of the PS, staff would call the nurse.			

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W 153	Continued From page 8 DSP-A was unsure who the PS notified. DSP-A revealed that the PS was the one to contact the families of the involved clients, and was the one who completed an incident report speaking to staff and reviewing their staff notes. During interview on 5/11/21 at 12:40 p.m., licensed practical nurse (LPN)-A identified all client to client altercations are reported to the PS. LPN-A revealed she was unaware of who was responsible for submitting a MAARC report to the SA as she had no part of that process. During interview on 5/12/21 at 2:06 p.m., the PS identified when she reported a client to client altercation she notified the program director (PD), then fills out the incident report by talking to staff and clients, and then reviews the progress notes and notified the quality improvement staff of the incident. The PS revealed the quality improvement staff reviewed all incidents reports to determine whether a SA report needed to be submitted, and then completed the investigation. If we are notified by QI that a SA report needs to be made then the PD or area director (AD) would file that report. Interview on 5/12/21 at 4:19 p.m., with program director (PD) identified that the quality improvement management makes the decisions if an event is reportable. She revealed that the PS notified her and the QI staff via an email when an incident occurred at which time the QI would then review the incident and lets her know if a SA report needed to be filed. The QI staff completed all investigations. She confirmed if a client had been slapped or hit that there should have been a SA report filed.	W 153		

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W 153	Continued From page 9 Interview on 5/13/21 at 9:32 a.m., with quality improvement staff identified she reviewed all incident reports and followed the Vulnerable Adult policy for reporting to the SA. She confirmed she had missed reporting on some of the facilities first incidents involving C2, C1, and C4. Her understanding of the policy was that the facility had 24 hours to make a SA report for any type of incident however, she revealed the Minnesota Department of Health identified it was to be made immediately, stating that immediate was vague to her. She confirmed she had been following the Vulnerable Adult policy and reporting within 24 hours. Review of the 8/20/18, Administrative Review of Incidents identified physical abuse as slapping, hitting, pinching, punching, or kicking by which bodily harm or trauma occurs. The policy identified any suspected or actual abuse will be reported immediately to the state Designated Reporting Agency and complaints/allegations and thoroughly investigated. Review of the 8/20/18, Vulnerable Adult policy identified adults receiving services will be protected from maltreatment. The policy identified abuse non accidental hitting, slapping, pinching, kicking, biting, or corporal punishment. Staff are to report immediately to the Program Director or Area Director. All allegations of suspected or actual abuse will be reported to MAARC (SA) within 24 hours of initial knowledge.	W 153		

Emailed on June 4, 2021

Administrator
Res Advantages Inc Luverne
107 South Blue Mound Avenue
Luverne, MN 56156

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: Z5OM11

Dear Administrator:

The above facility was surveyed on May 11, 2021 through May 12, 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:

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, MN 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 Silky. 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.

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
	24G330	A. BUILDING _____ B. WING _____	C 05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES ADVANTAGES INC LUVERNE	**107 SOUTH BLUE MOUND AVENUE LUVERNE, MN 56156**

(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 On 5/11/21 through 5/12/21, 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 complaint was found to be substniated: HG330004C (MN72471), however NO deficieninceis were cited due to actions implemented by facility prior to survey. However, as a result of the investigation deficiencies were identified at W149 and W153	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 that directed staff to immediately report alleged client to client abuse to State Agency (SA), for 3 of 3 clients (C1, C2, C4) who were reviewed for client altercations involving suspected or actual physical abuse. Findings include: Review of facility Incident Report dated 12/16/20, at 3:25 p.m., indicated when the program supervisor (PS) was coming from the north side	W 149		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 1	W 149		

of the home to where C2 was in the south side living room, PS heard C4, who had been sitting in a recliner in the living room say "no" to C2. As the PS came around the corner, the PS witnessed C2 bent over in front of C4 in the recliner. The PS observed C2 reaching for something and C4 saying "no". As the PS started to redirect C2, C2 came at PS and pushed PS just past the Christmas tree, pulled on the PS's shirt sleeve, kicked the Christmas tree, looked at the PS then went and slapped C4 in the stomach. PS redirected C2 who then sat down in a recliner and put his head in his hands. The Incident Report indicated C4 sustained a bruise from being hit by C2. The PS completed Incident Report, verbally notified the program director, and notified the guardian and case manager by email on 12/16/20. The facility's quality improvement committee was notified by email on 12/16/20, and had reviewed the incident report on 12/18/20. The facility failed to identify a report was made to the SA.

Review of facility Incident Report dated 12/28/20 at 7:30 p.m., identified C2 entered C1's room while the door was closed and started to take a DVD (digital movie) that was not his. When C1 told C2 it was his, C2 hit C1 in the chest leaving a red mark. The Incident Report indicated when staff checked on C2 in his bedroom, C2 looked mad so the staff left C2 alone. The staff told C2 they would get him a snack in a little bit. A short time later C2 went to the kitchen, went around the counter and came striking at staff. When the staff blocked themselves from C2's hits, C2 fell to floor. Staff put their hands out to keep him from getting up as there was another client sitting at the table. C2 grabbed the vacuum that was close by and swung it next to the other client almost

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	24G330	A. BUILDING _____ B. WING _____	C 05/12/2021

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W 149	Continued From page 2	W 149		

hitting them. C2 then knocked everything off the table, pulled the Christmas tree down, threw it and just laid on the floor. External parties notified were identified as C2's guardian and case worker by email and C1's guardian verbally, all on 12/28/20. The PS who filled out the incident report also notified the facility's quality improvement committee via email, and the incident report was reviewed on 12/29/20. The report failed to identify a report was made to the SA.

Review of facility Incident Report dated 4/7/21 at 6:30 p.m., indicated staff walked into the hallway and saw C2 entering his room and slamming the door. Staff spoke to C1 who reported that C2 had gone into C1's room when he was out of the room, and had taken one of C1's movies. When C1 tried to take the movie back from C2, C2 hit C1 with a closed fist on the right side of his head and on his back with the bedroom door. Staff checked for injuries and C1 had red marks on his right side and on his left side of his back. Staff contacted the PS and C1's guardian of the incident. The PS completed the incident form, notified the facility's quality improvement committee via email, had notified the program director, the area director, C2's guardian and C1's guardian verbally all on 4/7/21. The quality improvement manager reviewed the incident report on 4/8/21.

Review of the facility report to the SA submitted 4/8/21 at 10:19 a.m., identified the incident occurred on 4/7/21 at 6:36 p.m., the report indicated C1 was the Vulnerable Adult (VA), and the Alleged Perpetrator (AP) was C2. The allegation indicated C2 went into the C1's room and was attempting to take his movie. C2 hit C1

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W 149	Continued From page 3	W 149		

with a closed fist on the right side of his back. C2 then went into his bedroom, slammed the door, and stayed there until he calmed down. The incident was not reported tot he SA until the the day after the incident.

During interview on 5/11/21 at 11:59 a.m., direct support professional (DSP)-A identified when there is a client to client altercation, the first person they contact is the PS. DSP-A said if staff were unable to get a hold of the PS, staff would call the nurse. DSP-A was unsure who the PS notified. DSP-A revealed that the PS was the one to contact the families of the involved clients, and was the one who completed an incident report speaking to staff and reviewing their staff notes.

During interview on 5/11/21 at 12:40 p.m., licensed practical nurse (LPN)-A identified all client to client altercations are reported to the PS. LPN-A revealed she was unaware of who was responsible for submitting a report to the SA as she had no part of that process.

During interview on 5/12/21 at 2:06 p.m., with the PS identified when she reported a client to client altercation she notifies the program director (PD), then fills out the incident report by talking to staff and clients, and then reviews the progress notes and notifies the quality improvement staff of the incident. The PS revealed the quality improvement (QI) staff reviewed all incidents reports to determine whether a SA report needed to be submitted, and then completed the investigation. If we are notified by QI that a SA report needs to be made then the PD or area director (AD) would file that report.

Interview on 5/12/21 at 4:19 p.m., with program

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W 149	Continued From page 4	W 149		

director (PD) identified that the QI management makes the decisions if an event is reportable. She revealed that the PS notified her and the QI staff via an email when an incident occurred at which time the QI would then review the incident and lets her know if SA report needed to be filed. The QI staff completed all investigations. She confirmed if a client had been slapped or hit that there should have been a SA report filed.

Interview on 5/13/21 at 9:32 a.m., with quality improvement staff identified she reviewed all incident reports and followed the Vulnerable Adult policy for reporting to the SA system. She confirmed she had missed reporting on some of the facilities first incidents involving C2, C1, and C4. Her understanding of the policy was that the facility had 24 hours to make a SA report for any type of incident however, she revealed the Minnesota Department of Health identified it was to be made immediately, confirming that immediate was vague to her. She confirmed she had been following the Vulnerable Adult policy and reporting within 24 hours.

Review of the 8/20/18, Administrative Review of Incidents policy identified physical abuse as slapping, hitting, pinching, punching, or kicking by which bodily harm or trauma occurs. The policy identified any suspected or actual abuse will be reported immediately to the state Designated Reporting Agency and complaints/allegations and thoroughly investigated.

Review of the 8/20/18, Vulnerable Adult policy identified adults receiving services will be protected from maltreatment. The policy identified abuse non accidental hitting, slapping, pinching, kicking, biting, or corporal punishment. Staff are

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W 149	Continued From page 5 to report immediately to the Program Director or Area Director. All allegations of suspected or actual abuse will be reported to MAARC (SA) within 24 hours of initial knowledge.	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 allegation of client to client abuse to the designated State Agency (SA) for 3 of 3 client (C1, C2, C4) reviewed for allegations of physical abuse. Findings include: Review of facility Incident Report dated 12/16/20, at 3:25 p.m., indicated when the program supervisor (PS) was coming from the north side of the home to where C2 was in the south side living room, the PS heard C4, who had been sitting in a recliner in the living room say "no" to C2. As the PS came around the corner, the PS witnessed C2 bent over in front of C4 in the recliner. The PS observed C2 reaching for something and C4 saying "no". As the PS started to redirect C2, C2 came at PS and pushed PS just past the Christmas tree, pulled on the PS's shirt sleeve, kicked the Christmas tree, looked at the PS then went and slapped C4 in the stomach.	W 153		

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W 153	Continued From page 6 PS redirected C2 who then sat down in a recliner and put his head in his hands. The Incident Report indicated C4 sustained a bruise from being hit by C2. The PS completed an Incident Report, verbally notified the program director, and notified the guardian and case manager by email on 12/16/20. The facility's quality improvement committee was notified by email on 12/16/20, and had reviewed the incident report on 12/18/20. The report failed to identify a repot was made to state agency. Review of facility Incident Report dated 12/28/20 at 7:30 p.m., identified C2 entered C1's room while the door was closed and started to take a DVD (digital movie) that was not his. When C1 told C2 it was his, C2 hit C1 in the chest leaving a red mark. The Incident Report indicated when staff checked on C2 in his bedroom, C2 looked mad so the staff left C2 alone. The staff told C2 they would get him a snack in a little bit. A short time later C2 went to the kitchen, went around the counter and came striking at staff. When the staff blocked themselves from C2's hits, C2 fell to floor. Staff put their hands out to keep him from getting up as there was another client sitting at the table. C2 grabbed the vacuum that was close by and swung it next to the other client almost hitting them. C2 then knocked everything off the table, pulled the Christmas tree down, threw it and just laid on the floor. External parties notified were identified as C2's guardian and case worker by email and C1's guardian verbally, all on 12/28/20. The PS who filled out the incident report also notified the facility's quality improvement committee via email, and the incident report was reviewed on 12/29/20. The report failed to identify a report was made to the SA.	W 153		

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W 153	Continued From page 7	W 153		

Review of facility Incident Report dated 4/7/21 at 6:30 p.m., indicated staff walked into the hallway and saw C2 entering his room and slamming the door. Staff spoke to C1 who reported that C2 had gone into C1's room when he was out of the room, and had taken one of C1's movies. When C1 tried to take the movie back from C2, C2 hit C1 with a closed fist on the right side of his head and on his back with the bedroom door. Staff checked for injuries and C1 had red marks on his right side and on his left side of his back. Staff contacted the PS and C1's guardian of the incident. The PS completed the incident form, notified the facility's quality improvement committee via email, had notified the program director, the area director, C2's guardian and C1's guardian verbally all on 4/7/21. The quality improvement manager reviewed the incident report on 4/8/21. The report failed to identify a report was made to the SA.

Review of the facility's report to the SA submitted 4/8/21 at 10:19 a.m., identified the above incident occurred on 4/7/21 at 6:36 p.m., the report indicated C1 was the Vulnerable Adult (VA), and the Alleged Perpetrator (AP) was C2. The allegation indicated C2 went into the C1's room and was attempting to take his movie. C2 hit C1 with a closed fist on the right side of his back. C2 then went into his bedroom, slammed the door, and stayed there until he calmed down. The report had been filed the day after the incident.

During interview on 5/11/21 at 11:59 a.m., direct support professional (DSP)-A stated when there is a client to client altercation, the first person they contact is the PS. DSP-A said if staff were unable to get a hold of the PS, staff would call the nurse.

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W 153	Continued From page 8 DSP-A was unsure who the PS notified. DSP-A revealed that the PS was the one to contact the families of the involved clients, and was the one who completed an incident report speaking to staff and reviewing their staff notes. During interview on 5/11/21 at 12:40 p.m., licensed practical nurse (LPN)-A identified all client to client altercations are reported to the PS. LPN-A revealed she was unaware of who was responsible for submitting a MAARC report to the SA as she had no part of that process. During interview on 5/12/21 at 2:06 p.m., the PS identified when she reported a client to client altercation she notified the program director (PD), then fills out the incident report by talking to staff and clients, and then reviews the progress notes and notified the quality improvement staff of the incident. The PS revealed the quality improvement staff reviewed all incidents reports to determine whether a SA report needed to be submitted, and then completed the investigation. If we are notified by QI that a SA report needs to be made then the PD or area director (AD) would file that report. Interview on 5/12/21 at 4:19 p.m., with program director (PD) identified that the quality improvement management makes the decisions if an event is reportable. She revealed that the PS notified her and the QI staff via an email when an incident occurred at which time the QI would then review the incident and lets her know if a SA report needed to be filed. The QI staff completed all investigations. She confirmed if a client had been slapped or hit that there should have been a SA report filed.	W 153		

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W 153	Continued From page 9 Interview on 5/13/21 at 9:32 a.m., with quality improvement staff identified she reviewed all incident reports and followed the Vulnerable Adult policy for reporting to the SA. She confirmed she had missed reporting on some of the facilities first incidents involving C2, C1, and C4. Her understanding of the policy was that the facility had 24 hours to make a SA report for any type of incident however, she revealed the Minnesota Department of Health identified it was to be made immediately, stating that immediate was vague to her. She confirmed she had been following the Vulnerable Adult policy and reporting within 24 hours. Review of the 8/20/18, Administrative Review of Incidents identified physical abuse as slapping, hitting, pinching, punching, or kicking by which bodily harm or trauma occurs. The policy identified any suspected or actual abuse will be reported immediately to the state Designated Reporting Agency and complaints/allegations and thoroughly investigated. Review of the 8/20/18, Vulnerable Adult policy identified adults receiving services will be protected from maltreatment. The policy identified abuse non accidental hitting, slapping, pinching, kicking, biting, or corporal punishment. Staff are to report immediately to the Program Director or Area Director. All allegations of suspected or actual abuse will be reported to MAARC (SA) within 24 hours of initial knowledge.	W 153		

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	01345	A. BUILDING: _____ B. WING _____	C 05/12/2021

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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 5/11/21 through 5/12/21, a complaint investigation was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaint was found to be substantiated: HG330004C (MN72471) with a licensing order issued at MN Statute 626.557.	5 000		

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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. (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	5 815		

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RES ADVANTAGES INC LUVERNE	107 SOUTH BLUE MOUND AVENUE LUVERNE, MN 56156

(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
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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 allegation of client to client abuse to the designated State Agency (SA) for 3 of 3 client (C1, C2, C4) reviewed for allegations of physical abuse.

Findings include:

Review of facility Incident Report dated 12/16/20, at 3:25 p.m., indicated when the program supervisor (PS) was coming from the north side of the home to where C2 was in the south side living room, the PS heard C4, who had been sitting in a recliner in the living room say "no" to C2. As the PS came around the corner, the PS witnessed C2 bent over in front of C4 in the recliner. The PS observed C2 reaching for something and C4 saying "no". As the PS started to redirect C2, C2 came at PS and pushed PS just past the Christmas tree, pulled on the PS's shirt sleeve, kicked the Christmas tree, looked at the PS then went and slapped C4 in the stomach. PS redirected C2 who then sat down in a recliner and put his head in his hands. The Incident Report indicated C4 sustained a bruise from being hit by C2. The PS completed an Incident Report, verbally notified the program director, and notified the guardian and case manager by email

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	01345	A. BUILDING: _____ B. WING _____	C 05/12/2021

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on 12/16/20. The facility's quality improvement committee was notified by email on 12/16/20, and had reviewed the incident report on 12/18/20. The report failed to identify a repot was made to state agency.

Review of facility Incident Report dated 12/28/20 at 7:30 p.m., identified C2 entered C1's room while the door was closed and started to take a DVD (digital movie) that was not his. When C1 told C2 it was his, C2 hit C1 in the chest leaving a red mark. The Incident Report indicated when staff checked on C2 in his bedroom, C2 looked mad so the staff left C2 alone. The staff told C2 they would get him a snack in a little bit. A short time later C2 went to the kitchen, went around the counter and came striking at staff. When the staff blocked themselves from C2's hits, C2 fell to floor. Staff put their hands out to keep him from getting up as there was another client sitting at the table. C2 grabbed the vacuum that was close by and swung it next to the other client almost hitting them. C2 then knocked everything off the table, pulled the Christmas tree down, threw it and just laid on the floor. External parties notified were identified as C2's guardian and case worker by email and C1's guardian verbally, all on 12/28/20. The PS who filled out the incident report also notified the facility's quality improvement committee via email, and the incident report was reviewed on 12/29/20. The report failed to identify a report was made to the SA.

Review of facility Incident Report dated 4/7/21 at 6:30 p.m., indicated staff walked into the hallway and saw C2 entering his room and slamming the door. Staff spoke to C1 who reported that C2 had gone into C1's room when he was out of the room, and had taken one of C1's movies. When

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C1 tried to take the movie back from C2, C2 hit C1 with a closed fist on the right side of his head and on his back with the bedroom door. Staff checked for injuries and C1 had red marks on his right side and on his left side of his back. Staff contacted the PS and C1's guardian of the incident. The PS completed the incident form, notified the facility's quality improvement committee via email, had notified the program director, the area director, C2's guardian and C1's guardian verbally all on 4/7/21. The quality improvement manager reviewed the incident report on 4/8/21. The report failed to identify a report was made to the SA.

Review of the facility's report to the SA submitted 4/8/21 at 10:19 a.m., identified the above incident occurred on 4/7/21 at 6:36 p.m., the report indicated C1 was the Vulnerable Adult (VA), and the Alleged Perpetrator (AP) was C2. The allegation indicated C2 went into the C1's room and was attempting to take his movie. C2 hit C1 with a closed fist on the right side of his back. C2 then went into his bedroom, slammed the door, and stayed there until he calmed down. The report had been filed the day after the incident.

During interview on 5/11/21 at 11:59 a.m., direct support professional (DSP)-A stated when there is a client to client altercation, the first person they contact is the PS. DSP-A said if staff were unable to get a hold of the PS, staff would call the nurse. DSP-A was unsure who the PS notified. DSP-A revealed that the PS was the one to contact the families of the involved clients, and was the one who completed an incident report speaking to staff and reviewing their staff notes.

During interview on 5/11/21 at 12:40 p.m., licensed practical nurse (LPN)-A identified all

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client to client altercations are reported to the PS. LPN-A revealed she was unaware of who was responsible for submitting a MAARC report to the SA as she had no part of that process.

During interview on 5/12/21 at 2:06 p.m., the PS identified when she reported a client to client altercation she notified the program director (PD), then fills out the incident report by talking to staff and clients, and then reviews the progress notes and notified the quality improvement staff of the incident. The PS revealed the quality improvement staff reviewed all incidents reports to determine whether a SA report needed to be submitted, and then completed the investigation. If we are notified by QI that a SA report needs to be made then the PD or area director (AD) would file that report.

Interview on 5/12/21 at 4:19 p.m., with program director (PD) identified that the quality improvement management makes the decisions if an event is reportable. She revealed that the PS notified her and the QI staff via an email when an incident occurred at which time the QI would then review the incident and lets her know if a SA report needed to be filed. The QI staff completed all investigations. She confirmed if a client had been slapped or hit that there should have been a SA report filed.

Interview on 5/13/21 at 9:32 a.m., with quality improvement staff identified she reviewed all incident reports and followed the Vulnerable Adult policy for reporting to the SA. She confirmed she had missed reporting on some of the facilities first incidents involving C2, C1, and C4. Her understanding of the policy was that the facility had 24 hours to make a SA report for any type of incident however, she revealed the Minnesota

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5 815	Continued From page 6 Department of Health identified it was to be made immediately, stating that immediate was vague to her. She confirmed she had been following the Vulnerable Adult policy and reporting within 24 hours. Review of the 8/20/18, Administrative Review of Incidents identified physical abuse as slapping, hitting, pinching, punching, or kicking by which bodily harm or trauma occurs. The policy identified any suspected or actual abuse will be reported immediately to the state Designated Reporting Agency and complaints/allegations and thoroughly investigated. Review of the 8/20/18, Vulnerable Adult policy identified adults receiving services will be protected from maltreatment. The policy identified abuse non accidental hitting, slapping, pinching, kicking, biting, or corporal punishment. Staff are to report immediately to the Program Director or Area Director. All allegations of suspected or actual abuse will be reported to MAARC (SA) within 24 hours of initial knowledge.	5 815		