Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

July 7, 2021

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

RE: Event ID: 8ZLI11

Dear Administrator:

On June 14, 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. This survey found one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the survey we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the electronically delivered "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy effective June 14, 2021.

One or more of these deficiencies do not meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID):

W266 CRF 42 §483.450 Client Behavior & Facility Practices

Federal certification deficiencies are delineated on the enclosed form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC).

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 correctionk 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.

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by August 8, 2021, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

Sincerely,

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

cc: Licensing and Certification File

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

PRINTED: 07/07/2021
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 06/14/2021

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 6/10/21 through 6/14/21, an abbreviated survey was conducted to investigate HG330005C. The facility was found NOT to be in compliance with the requirements of 42 CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). In addition, the Condition of Participation: Client Behavior & Facility Practices 42 CFR 483.450 was found not met. An extended survey in the the area of client protection was conducted. The following complaint was found to be substantiated: HG330005C (MN73502). Deficiency issued at W285. An Immediate Jeopardy (IJ) was identified at W285 on 6/11/21, at 5:51 p.m. The IJ began on 6/3/21, at approximately 5:43 a.m. when C2 was exhibiting dangerous behaviors by screaming, throwing objects, then charging after direct support professional (DSP)-B. DSP-B ran from the south side of the facility to the north side of the facility and barricaded herself behind the north entrance door until law enforcement arrived. The facility failed to develop and implement corrective actions, or modify interventions to prevent future occurrences. The facility's regional director was informed of the IJ situation on 6/11/21, at 5:51 p.m. The IJ was removed on 6/14/21, at 2:26 p.m. when the facility ensured constant supervision of C2 on the overnight shift by adding an extra staff, and arranged for additional staff	W 000	POC recived 7/16/21 POC rejected 8/1/21 POC resubmitted 8/3/21 POC approved 8/3/21 Liz Silkey	

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 000	Continued From page 1 training related to C2's aggressive behaviors.	W 000		
W 266	CLIENT BEHAVIOR & FACILITY PRACTICES CFR(s): 483.450 The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.450 Client Behavior & Facility Practices, was not met. The facility failed to provide a safe environment for (C1, C4, C5, C6) due to the physically aggressive behaviors exhibited by C2. Staff are not able to manage C2's behaviors and have had to call local law enforcement when C2 is out of control. This resulted in an Immediate Jeopardy (IJ) for (C1, C4, C5, C6) due to the risk of physical abuse and placing all clients at risk of serious harm, injury or death. The IJ began on 6/3/21, at approximately 5:43 a.m. when C2 was exhibiting dangerous behaviors by screaming, throwing objects, then charging after direct support professional (DSP)-B. DSP-B ran from the south side of the facility to the north side of the facility and barricaded herself behind the north entrance door until law enforcement arrived. The facility failed to develop and implement corrective actions, or modify interventions to prevent future occurrences. The facility's regional director was informed of the IJ situation on 6/11/21, at 5:51 p.m. The IJ was removed on 6/14/21, at 2:26 p.m. when it could be verified the facility had	W 266	Tag W 266 • The Program comprehensively assessed C2's behaviors and staff completed additional training on C2's Behavior Support plan. This training was held 6/24/21. • A Physical Intervention Alternatives and Positive Behavior Supports training was held on 7/1/21. • Staff were retrained on the supervision needs of each individual, including C1, C2, C4, C5 and C6. This was completed by 6/15/2021. • Double staffing was implemented in the program 24 hours per day while C2 is present in the program this began on 6/14/21. • Staff were trained to remove C1 to a safe location during any behavioral incident and provide supervision. This training was completed by 6/15/21. • A Service Termination Notice was issued to C2 on 5/18/21. • C2 moved out of the program on 7/4/21. • Ongoing monitoring of client behavioral needs will be completed by the Program Supervisor and Program Director/QIDP by reviewing behavioral data at least monthly going forward. The PS/PD will review each behavioral incident after they occur to immediately implement interventions to manage inappropriate client behavior	

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W 266	Continued From page 2 implemented corrective action. Findings include: See W285: The facility failed to provide a safe environment for (C1, C4, C5, C6) due to the physically aggressive behaviors exhibited by C2.	W 266	with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. • The program will develop and implement corrective actions or modify interventions following any behavioral occurrence going forward. • All corrections were completed as of 7/4/21. • Responsible Parties- Program Supervisor, Program Director/ QIDP and Area Director.	
W 285	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to provide a safe environment for (C1, C4, C5, C6) due to the physically aggressive behaviors exhibited by C2. Staff are not able to manage C2's behaviors and have had to call local law enforcement when C2 is out of control. This resulted in an Immediate Jeopardy (IJ) for (C1, C4, C5, C6) due to the risk of physical abuse and placing all clients at risk of serious harm, injury or death. The IJ began on 6/3/21, at approximately 5:43 a.m. when C2 was exhibiting dangerous behaviors by screaming, throwing objects, then charging after direct support professional (DSP)-B. DSP-B ran from the south side of the facility to the north side of the facility and barricaded herself behind the north entrance door until law enforcement arrived. The facility failed	W 285		

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W 285

Continued From page 3

to develop and implement corrective actions, or modify interventions to prevent future occurrences. The facility's regional director was informed of the IJ situation on 6/11/21, at 5:51 p.m. The IJ was removed on 6/14/21, at 2:26 p.m. when it could be verified the facility had implemented corrective action.

Findings include:

A facility incident report dated 6/3/21 identified C2 had a behavioral incident which resulted in C1 being unsupervised:

On 6/3/21, at 5:30 a.m. (note: precursor to incident began approximately 1:00 a.m.) at approximately 1:00 a.m. C2 was in his bedroom and turned the Kindle tablet volume up to the maximum level. DSP-B opened C2's door and asked if he would please turn the volume down. C2 did not want to turn the volume down and put his blanket over his face. DSP-B stepped further into C2's room to turn the tablet down and C2 allowed it. Approximately two hours later, C2 again turned the volume up on the tablet. DSP-B again opened C2's door and asked that he please turn it down as other clients were trying to sleep. C2 again put his blanket over his head though allowed DSP-B to turn the volume down. At approximately 5:30 a.m., DSP-B was finishing assisting C1 with using the commode in her room. C2 again had turned the volume up loud on his tablet. DSP-B opened C2's door and asked if he could turn the volume down a bit as C1 was trying to go back to sleep. C2 got up off his bed and started yelling (in his dinosaur voice) and coming after DSP-B. DSP-B walked halfway down the southside hallway and was still able to visualize C2. C2 came out of his room then

W 285

Tag W 285

- The Program comprehensively assessed C2's behaviors and staff completed additional training on C2's Behavior Support plan. This training was held 6/24/21.
- A Physical Intervention Alternatives and Positive Behavior Supports training was held on 7/1/21.
- Staff were retrained on the supervision needs of each individual, including C1, C2, C4, C5 and C6. This was completed by 6/15/2021.
- Double staffing was implemented in the program 24 hours per day while C2 is present in the program this began on 6/14/21.
- Staff were trained to remove C1 to a safe location during any behavioral incident and provide supervision. This training was completed by 6/15/21.
- A Service Termination Notice was issued to C2 on 5/18/21.
- C2 moved out of the program on 7/4/21.
- Ongoing monitoring of client behavioral needs will be completed by the Program Supervisor and Program Director/QIDP by reviewing behavioral data at least monthly going forward. The PS/PD will review each behavioral incident after they occur to immediately implement interventions to manage inappropriate client behavior with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

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W 285	Continued From page 4 proceeded to open C1's bedroom door. DSP-B told C2 that was not his room; he then came charging after DSP-D. C2 went into his room and started to throw and break things. DSP-B called the police at approximately 5:43 a.m. due to C2 being agitated and throwing items in his room. The police arrived, however, C2 did not appear to be agitated at that time. Staff called the PS around 5:59 a.m.; PS arrived at 6:02 a.m. Upon arrival she walked past C2's bedroom door, there was broken glass and objects on the floor. C2 was sitting on his bed; SP said hi and good morning, then pulled C2's door shut and went to talk to the police. The police stated they had no interaction with C2 as he was not agitated when they arrived and they then left. At 6:10 a.m., C2 was standing in the hallway next to the entryway door. C2 stated to yell and reach for PS. PS shut the door and C2 proceeded to hit the door, threw the Kindle tablet, and knocked over chairs. At 6:30 a.m., guardian-A was called and agreed to come to the facility. Staff did visual checks on C2 every 15 minutes. Every time C2 would visualize staff he would become agitated all over again. Guardian-A arrived at the facility at approximately 7:05 a.m. Guardian-A talked with C2 but then C2 began to yell and started to hit guardian-A. C2 chased guardian-A and PS outside. C2 proceeded to attempt to hit guardian-A and also hit and kicked cars that were nearby. C2 left the premises with guardian-A at approximately 7:30 a.m., with a plan to return to the facility on 6/6/21. When C2 went outside, staff were able to check on C1. C1 indicated she was scared due to hearing C2 yelling, throwing and breaking things. When interviewed on 6/11/21, at 8:30 a.m. DSP-B confirmed having worked the night shift from 6/2/21, into the morning of 6/3/21. DSP-B stated	W 285	• The program will develop and implement corrective actions or modify interventions following any behavioral occurrence going forward. • All corrections were completed as of 7/4/21. • Responsible Parties- Program Supervisor, Program Director/ QIDP and Area Director.	

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

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W 285	Continued From page 5 C2 was awake pretty much all night long with behaviors starting at approximately 1:30 a.m. C2 had turned the volume on his tablet up to the maximum level. DSP-B asked C2 to turn the volume down and he put his blanket over his head. When DSP-B then asked if she could turn down the volume, C2 did not respond though allowed DSP-B to turn down the volume. A couple hours later the same thing happened and C2 allowed DSP-B to turn the volume down on his tablet. At approximately 5:00 a.m., C1 called for DSP-B, and asked to use the commode in her room. DSP-B stated it was quiet in C2's room so she assumed he was asleep. Once DSP-B had gotten C1 back to bed and exited her room, the volume on C2's tablet instantly increased to the maximum level. DSP-B opened C2's door and asked him again to turn the volume down; he then charged after her. DSP-B started going down the south hall; C2 went back in his room and started throwing things at DSP-B and pulling things off the wall and throwing down the hall at DSP-B. Once he finished throwing things, he went back into his room. DSP-B waited in the hallway. Eventually, C2 came out to the hallway still screaming, then opened C1's bedroom door like he was going to enter the room. DSP-B told C2 it was C1's room, and he could not go in there, that is when he came charging down the hallway at DSP-B screaming. DSP-B then went to the north unit and shut the door, holding the door shut while C2 pulled and banged on the door screaming. DSP-B stated when C2 would stop pulling on the door she would peek out; he was still there and would charge the door and start pulling again. After doing this a couple times DSP-B called the police because she knew she could not get to C1 safely and also knew C1 was awake and hearing	W 285		

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W 285	Continued From page 6 C2 screaming. DSP-B confirmed remaining on the north unit until the police arrived which left C1 unsupervised. The police stated they had visualized C2 in the south entryway when they arrived. The police did not enter the facility and advised DSP-B they were unable to detain C2 and recommended DSP-B call the PS. The police remained outside the facility until the PS arrived. DSP-B stated she remained at the facility until guardian-A arrived because C2 was not calming down and staff could not get to C1. Guardian-A arrived at approximately 7:45 a.m.; once guardian-A got C2 into the garage, DSP-B was able to safely get to C1's room and get her up and ready for work. DSP-B stated C1 was really shaken up when she got to her. C1 had indicated when no one came she was afraid that C2 would come into her room and get to her. C1 told DSP-B that when C2 became quiet she thought she was safe, but then when he started screaming she got scared all over again. DSP-B confirmed following that episode being uncomfortable staying alone at night with C2 in the facility. DSP-B stated, "Honestly after that I stay on the north side but do checks on C1 throughout the night. I've told [PS] I'm uncomfortable. Before this episode he would sleep most of the time and might get up and use the bathroom but would go back to bed." C2's undated Service Recipient Information Cover Sheet indicated diagnoses including: autism spectrum disorder with intellectual disability (neurodevelopment disorder that causes a wide range of impairments in social communication and restricted and repetitive behaviors, with limited intellectual functioning and adaptive behavior), metabolic disorder (group of health conditions leading to increased risk of	W 285		

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W 285	Continued From page 7 heart diseases and related problems), and epilepsy (seizure disorder). C2's Behavior Action Plan dated 1/15/21, identified physical aggression including but not limited to C2 pushing staff, grabbing his peers, shaking his peers, pushing staff into the wall, attempting to kick staff, kicking staff, hitting staff, and/or ripping staffs clothing. The plan also identified invading other's space or violating boundaries including but not limited to C2 following his peers around too closely, touching peers clothing when sitting too closely to them, talking to his peers too closely (within one inch from their face), and/or going into peer's room and taking their items without their permission. Proactive interventions when behavior was not being demonstrated directed staff to keep C2 engaged in a preferred activity or talk about the things he likes. Staff were to avoid giving demands or bringing up things that C2 didn't like to talk about. Staff were to avoid telling C2 "no", and should use first then statements. "C2 first let's put your coat and hat on then we can go on a van ride." Staff could also use statement that indicate when C2 could access something that he wanted. Staff were to provide as much choice in C2's day as possible and allow him to have as much control over his environment as possible. Staff were also directed to utilize a schedule to structure C2's time and avoid boredom. Staff were also to give C2 one-to-one time, build rapport, and give C2 behavior specific praise for behaviors they wanted to see more of. Reactive interventions to the physical aggression directed staff to discontinue prompting at this level as verbal de-escalation was not likely to be effective after the initial prompt to stop. Staff should give neutral attention ignoring this behavior. Staff	W 285		

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W 285	Continued From page 8	W 285		

should not tell C2 that he is hurting anyone or that he is being inappropriate as this is negative attention may make it more probable that this behavior will occur again in the future. Staff should follow the steps as taught in physical interventions alternatives (PIA-Techniques to protect staff and others-defensive physical maneuvers to keep staff and others from being injured when someone becomes aggressive.

C2's Risk Assessment Detail last modified 4/4/21, indicated C2 likes to make noises such as playing with toys, TV/radio up loud, make bodily noises, and to invade others personal space. This may provoke others behaviors towards C2.

C2's Functional Behavior Assessment dated 12/15/20, indicated C2's physical aggression behavior was classified as severe. C2 had been observed to display behaviors that have the ability to significantly injure another individual. From September 2nd, 2020 to December 15th, 2020, C2 had engaged in a total of 19 instances of physical aggression. This information was gathered from staff shift notes.

C1's undated Service Recipient Information Cover Sheet indicated diagnoses including: mild intellectual disability, cerebral palsy (group of disorders that affect movement, muscle tone, balance, and posture), bilateral spastic hemiparesis (both sides of the body is afflicted with weakness, but is not paralyzed), and seizure disorder.

C1's Risk Assessment Detail dated 6/3/20, indicated C1 would be unable to defend herself against abuse due to her physical limitations.

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W 285	Continued From page 9 C4's undated Service Recipient Information Cover Sheet indicated diagnoses including: moderate intellectual disability and bipolar affective disorder (mental health condition that causes extreme mood swings). C4's Risk Assessment Detail dated 6/14/21, indicated it was unclear whether C4 knew what to do during an abusive situation. C5's undated Service Recipient Information Cover Sheet indicated diagnoses including: severe intellectual disorder, Down's syndrome, and dementia. C5's Risk Assessment Detail dated 4/6/21, indicated due to physical limitations, C5 is unable to defend herself against abuse. C6's undated Service Recipient Information Cover Sheet indicated diagnoses including: profound intellectual disability, cerebral palsy, and seizure disorder. C6's Risk Assessment Detail dated 5/19/21, indicated due to C6's size, disability, and strength level, she would be unable to defend herself against abuse. C2's incident reports indicated multiple behavioral incident with other clients or staff: - 10/17/20 at 3:30 p.m. C2 became agitated after being told by staff that he couldn't go outside. When C4, who was able to go outside by himself, attempted to leave the house, C2 grabbed C4 around the arms, shook C4 and started screaming. Staff directed C2 to release C4; when C2 released C4 he shoved C4 in the process. C2	W 285		

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W 285	Continued From page 10 then grabeed direct support professional (DSP)-E, who was able to get away. C2 then chased DSP-E to the south side kitchen. C2 then attempted to grab C6, but staff intervened before he could get to her. - 11/17/20, at 8:15 p.m. DSP-E found C2 in the basement and asked C2 to go upstairs so they could finish the med pass and putting other clients to bed. C2 became upset and would not listen to DSP-E. DSP-E went to get help from DSP-F; C2 would not listen to either staff. DSP-F approached C2 and he hit her. C2 then began screaming and started to chase DSP-E; C2 grabbed her shirt and scratched her. C2 would not let go of DSP-E's shirt and the shirt ended up ripping when DSP-E tried to get away and the staff fell to the floor. C2 then laid down on the floor and would not get up. Staff called the program supervisor (PS) to come in for assistance. The PS came to the facility and talked to C2 who eventually got up, called his parents, then went to bed. - 12/8/20, at 3:05 p.m. C2 slapped DSP-C across the left side of face leaving a big red mark. DSP-C stated that C2 did not want to take a shower earlier that morning because he was watching TV and was going to wait until later in the afternoon to do it. DSP-C stated around 3:05 p.m. she asked C2 to take his shower. C2 then charged at DSP-C, slapped her and went to his room and slammed the door. - 12/9/20, at 2:00 p.m. DSP-C went to let C2 know it was someone else's turn for the TV and that the movie he was watching was not his and needed to return it to the other client. C2 threw the remote at the TV, got up and threw the dining	W 285		

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W 285	Continued From page 11	W 285		

room chair on the ground, pushed everything on the table to the ground and then came running after DSP-C. C2 hit DSP-C on the neck/back twice and pushed her up against the wall twice in a row.

- 12/9/20, at 4:30 p.m. C2 ran towards DSP-F and scratched, hit, kicked, pushed, and pulled DSP-F to the ground along with C2. C2 broke DSP-F's glasses then laid on the floor with his hands on his face. DSP-F made sure C2 was not hurt and let him lay on the floor to calm down as C2 did not want to get up.

- 12/16/20, at 3:25 p.m. the program supervisor (PS) heard C4 tell C2 "No". PS observed C2 bend over in front of C4, who was seated in a recliner, and reach for something. C4 kept telling C2, "No." PS attempted to verbally redirect C2. C2 came at PS and pushed her past the Christmas tree, then pulled on PS's shirt sleeve. PS asked C2 to let go and he did. C2 then kicked the Christmas tree, looked at PS, then went over to the recliner where C4 was sitting and slapped C4 on the stomach.

- 12/28/21, at 7:30 p.m. C2 went into C3's bedroom while the door was closed and started to take a DVD that was not his. C3 confronted C2 who then hit C3 in the chest leaving a red mark. A short time later C2 came into the kitchen and DSP-F told him she would get him a snack in a little bit. C2 then came around the kitchen corner and came after DSP-F and started hitting her. DSP-F blocked themselves from C2's hits and C2 then fell to the floor. While on the floor, DSP-F put their hands out to keep C2 from getting up because another client was sitting at the table where he was positioned on the floor. C2

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W 285	Continued From page 12 grabbed the vacuum cleaner an swung it next to the client sitting at the table but he did not hit them. - 3/23/21, at 5:20 p.m. C2 assisted DSP-E for a short time with preparing biscuit dough for supper. C2 then went to go watch TV while DSP-E continued preparing supper. DSP-H was on the north side of the facility. While DSP-E continued to prepare supper, C2 was able to get on the staff laptop at the desk. DSP-E attempted to distract C2 by asking him to help more with supper. DSP-H came over to the south side of the facility and also attempted to get C2 off laptop. Staff had informed the PS at approximately 5:20 p.m. that C2 had the laptop for about 30 minutes and was not getting off of it and attempted distractions including supper, calling dad, and a bath. PS came to the facility to assist staff with obtaining the laptop. When PS arrived C2 was sitting at the desk watching YouTube on the laptop with his supper next to him untouched. PS asked C2 to move to the kitchen table to eat supper; C2 did not look up until PS moved his plate a bit, then went right back to the laptop. PS lifted up the laptop by the corner saying to him lets eat supper. C2 stood up, yelled, picked up his plate and dumped it over his head. C2 then tossed the kitchen table chair, grabbed staff's backpack and threw it into the kitchen at DSP-E. C2 then went after DSP-E and pushed her into the dishwasher, pulled her hair, and broke her glasses. PS then got in between DSP-E and C2. C2 grabbed PS by the jacket and pulled PS to him. PS noticed a knife nearby and went to grab it to move it out of the way; C2 grabbed the knife as well. PS was able to get the knife away from C2 and safely put it in the sink. C2 then kicked PS multiple times in the legs,	W 285		

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W 285	Continued From page 13 grabbed PS again, and pulled PS to the ground kicking her in the legs. PS stood up, C2 then grabbed the backpack and threw it, then grabbed PS again and attempted to pull PS down; PS then hit her left eye on the counter. PS was able to get away and C2 then sat in the middle of the kitchen floor. At approximately 6:50 p.m., DSP-H texted PS that C2 had attacked him at the desk. PS called the program director (PD) to see if she would go with her to the facility to assist with C2 at that time. Prior to PS and PD's arrival, DSP-H was sitting at the desk looking at the medication that just came in from the pharmacy and C2 came out of his room. DSP-H put the medication down and looked up at C2 to talk to him and C2 started running at DSP-H. C2 attempted to take DSP-H's phone out of his hand, then hit DSP-H's glasses off of his face. C2 then sat down on the floor and started kicking DSP-H. When DSP-H got up to retrieve the glasses, C2 grabbed the glasses and threw them into the entryway. PS arrived at the facility at 7:00 p.m. and C2 was seated in front of the southside basement door on the floor. PS asked C2 why he was sitting on the floor and C2 raised his hand. PS took C2's hand and C2 attempted to pull PS down to the floor; PS pulled away. PD arrived and tried the same thing and C2 tried to pull PD down as well. PD talked with C2 and had other staff open the front door so C2 could get to his stuffed animal. PD was able to get C2 to pick up the recycling he had thrown and PS gave C2 his stuffed animal. C2 took his medications, snack and seemed ok. - 4/7/21, at 6:30 p.m. DSP-E was assisting another staff with a client on the north side of the facility. Upon return to the south side of the facility, DSP-E observed C2 enter his bedroom and slam the door. C3 indicated C2 had entered	W 285		

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W 285	Continued From page 14 C3's bedroom when C3 was not in there, and took one of C3's movies. C3 tried to take the movie away from C2 and told him it was not his. C2 then hit C3 with a closed fist on his right side and also hit C3 in the back with C3's bedroom door while attempting to close it to keep C3 out of his room. DSP-E checked C3 for injuries and C3 had two red marks on his right side and on his left side of his back. - 4/8/21, at 6:00 p.m. DSP-I observed C2 take a DVD from the living room that belonged to another client, to his room. DSP-I followed C2 to his room; C2 was seated down at the head of his bed. DSP-I took hold of the DVD and advised C2 that it belonged to another client and he did not have permission to take it. DSP-I attempted to take the DVD from C2, but C2 would not let go. DSP-I again advised C2 that he was taking the DVD back and pulled it from C2's hands. C2 then raised his hands and attempted to push DSP-I as he backed away from him. Once at the foot of the bed, DSP-I turned to exit the room; C2 grabbed DSP-I by the back of the shirt and yanked them back causing DSP-I to lose his balance. DSP-I fell to the floor on his back and his head slightly hit the wall trim. C2 then grabbed the cords of his TV and DVD player and yanked on them. C2 then reached for his Tonka truck and threw it towards DSP-I as they were exiting C2's bedroom and shutting the door. DSP-I kept C2's door closed until C2 was finished throwing things, and checked on the other clients. DSP-I then checked on C2 to see if he had calmed down. C2 was seated at the head of the bed and immediately grabbed his radio and threw it towards DSP-I who again shut the door until he stopped throwing things.	W 285		

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W 285	Continued From page 15 - 4/23/21, at 11:45 a.m. DSP-D was getting lunch ready for the clients and asked C2 to sit at the dining room table. DSP-D asked C2 to take his medication and set a glass of milk in front of him. DSP-D retrieved C2's plate, and when returning to the table C2 threw his milk and started to go after DSP-D. DSP-D exited through the living room to the southside hallway. C2 entered the southside hallway from the other direction; at that time C3 was coming around the corner. C2 then struck C3 on the head. C2 then entered his bedroom and started throwing things. At approximately 12:30 p.m., DSP-C went into the kitchen to get something out of the refrigerator for another client. C2 came up behind DSP-C, cornered her in the kitchen, and began hitting her on the back and shoulders. C2 then reached for DSP-C's cell phone, which was in her sweatshirt pocket. DSP-C was able to get away from C2 and went into another client's room and closed the door. C2 then started throwing anything he could find. - 5/4/21, at 11:00 a.m. DSP-I was assisting C2 with a shower and morning grooming. While assisting C2 with shaving, and while putting shaving cream on C2's face, C2 used one arm to push DSP-I away then grabbed DSP-I by the neck of the shirt leaving a scratch on staff's chest from neck to cleavage area. C2 then threw himself to the floor trying to pull DSP-I down with him. Once C2 lost his grip on staff's shirt he started kicking his feet and grabbing for things. DSP-I then left the bathroom and shut the door while C2 continued to throw things. Once C2 had calmed, DSP-I opened the door and C2 had gotten back in the shower. DSP-I advised C2 if he was ready to get up to shut the water off, then get out and staff stepped back out just in case.	W 285		

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After DSP-I heard the water shut off, she went back into the bathroom to assist C2 with drying off and getting dressed. C2 started yelling again and charged the door slamming it shut, then started hitting, throwing and breaking things. DSP-I let C2 be at that point and C2 eventually dried and dressed himself then went to his bedroom.

- 5/5/21, at 4:00 a.m. DSP-A heard C2 yelling deeply and loudly in his room, then could be heard throwing things in his room. This lasted approximately 10 minutes though C2 did not leave his room during that time. At 7:30 a.m., C2 exited his room to use the bathroom, then returned to his room. At 8:00 a.m. DSP-A entered C2's room to assist with changing his clothes as he had been incontinent of urine. At 8:15 a.m., day staff - DSP-I took over supervision for the south side of the facility. C2 took his medications, ate breakfast, then returned to his room. At approximately 8:40 a.m., C2 charged at DSP-I as she was walking past his bedroom door. DSP-I attempted to get C2 into his bedroom so she could shut his door. C2 grabbed DSP-I's shirt and pushed her hard into C1's bedroom door (located to the right of C2's doorway). C2 then fell to the floor and pulled DSP-I down with him. DSP-I was able to get up and back away from C2. C2 sat on the floor screaming and kicking before sitting in silence in front of C1's door for approximately 30 minutes. DSP-I informed the PS of the situation and also to inform PS that she could not safely get to C1 to administer the clients medications or assist them with toileting. Shortly after that, C2 got up and sat at the dining room table and DSP-I assisted him. When C2 got up to use the bathroom and the area was safe, DSP-I was able to enter C1's room and assist her

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W 285	Continued From page 17 with morning cares. When C2 exited the bathroom, he observed DSP-D in the front entryway and charged after her. DSP-D barricaded herself behind the door entering the north side of the building and held it shut before C2 could get to her. C2 proceeded to throw himself at the north entrance door, beating on the walls and the door attempting to get to DSP-D. While DSP-D was holding the door shut, licensed practical nurse (LPN)-A had come up from the basement and also helped DSP-D to hold the door shut. Staff could not approach C2 safely and LPN-A subsequently called law enforcement at approximately 9:30 a.m. Staff met the police outside when they arrived at 9:35 a.m. Shortly after the two police arrived onsite, DSP-I heard them talking with C2. C2 went to punch one of the officers; the officers then each grabbed one of C2's arms and brought C2 down to the floor. C2 continued to be combative and screaming for 30+ minutes before the ambulance arrived. Once the ambulance arrived, the EMT (emergency medical technician) gave C2 an injection of Zyprexa (an antipsychotic medication) 10 milligrams (mg) in his upper left arm. C2 then calmed down a few minutes later. The paramedics used restraints on C2 while transporting to the ER at approximately 10:00 a.m. Once at the ER, C2 allowed the staff there to complete vital signs. The ER physician was asked about a 72 hour emergency hold for C2's safety and also for the safety of the other clients at the facility. The physician stated that sometimes they would not do that unless he was suicidal or something was psychologically wrong with him. C2's parents arrived at the ER as well. C2 was still restrained in the bed. Blood work and scans were performed and results of the scan showed C2 was moderately full of bowel and needed a bowel clean out. C2 was released	W 285		

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W 285	Continued From page 18 from the hospital ER and went to his parent's home. Parent's indicated they would complete the clean out. - 5/21/21, at 10:00 a.m. (note: precursor to incident began at approximately 8:30 a.m.) at approximately 8:30 a.m., overnight staff DSP-B, walked over to the north side of the facility to gather her belongings prior to leaving her shift; C2 followed her. C2 sat down in one of the recliners on the north side and started to utilize his Kindle tablet. DSP-B stated to C2, "Hey buddy, can't be over here." C2 ignored DSP-B and continued to play with his Kindle. DSP-B then stated, "Can't be over here, let's go over to the other side." C2 then walked over to the south side of the facility and slammed the doors. At 10:00 a.m. DSP-F went to C2's room and asked if he wanted to take a shower. C2 nodded yes and DSP-F had him pick out his clothes. DSP-F and C2 then went into the southside bathroom where DSP-F assisted C2 with washing his hair and his body. DSP-F then started to put shaving gel on his face. C2 did not say anything to staff, but when they started to put the gel on his face he hit DSP-F in the chest. C2 then started to scream and grabbed DSP-F. The floor was wet and when he pulled on staff, C2 slipped and fell on the floor backwards bringing DSP-F down with him while still holding onto her. DSP-F hit her right knee on the floor. When DSP-F got up off the floor, C2 grabbed the trash can and threw it. DSP-F left the bathroom and shut the door, standing outside the door in the hallway for approximately two minutes, then popped her head inside the door and C2 was back in the shower. DSP-F left C2 alone for five minutes while standing outside of the door, and the put his clothes and towel on the counter. At that time	W 285		

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W 285	Continued From page 19 she also told C2 these items were in the bathroom on the counter and that he could shut the water off when finished. C2 did not answer or respond. DSP-F then walked to the north side of the facility and at that time heard the water shut off. DSP-F checked on C2 10-15 minutes later and he was dressed and in the garage with his Kindle tablet. While C2 was in the garage, DSP-F went to clean up the bathroom. C2 continued to have the dark/black eyes look (which was an indicator of potential explosive aggressive interfering behaviors) and was engaged in playing on his Kindle tablet. DSP-F continued to do visual checks on C2 and he remained in the garage using his Kindle tablet. At noon, DSP-F walked to the doorway to the garage and let C2 know his food was ready for lunch. C2 got up and came around the van walking towards staff, his eyes remained dark/black and he threw the Kindle towards DSP-F. DSP-F shut the door and walked to the entryway leading into the north side of the facility an heard C2 come inside an sit down at the table. After approximately 15 minutes, DSP-F went to do a visual check on C2 and he had eaten his lunch, put his plate in the sink, and was back in the garage on the Kindle tablet. - 6/7/21, at 7:55 a.m. DSP-C had started giving C2 his Miralax (a laxative) mixed with liquid for his "clean out." When DSP-C went to administer the third dosage, (C2's bedroom doorway), he pushed DSP-C and did his dinosaur voice and started to run towards DSP-C and tried to grab her. As DSP-C was exiting to the northside entryway, she heard and saw C2 go into the south bathroom and slammed the door. DSP-D checked on C2 approximately 30 minutes later. As DSP-D opened the entryway door, C2 started	W 285		

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W 285	Continued From page 20 running towards her yelling. As DSP-D was closing the entryway door, she heard and visualized C2 go into the south bathroom. After 10 minutes, DSP-D checked on C2 again and he was in his bedroom asleep at that time. When interviewed on 6/10/21, at 10:50 a.m. PS confirmed C2 had aggressive behaviors and had a couple incidents where he hit C3. C3's guardian-B did not think C3 was safe when C2 was at the facility so she took him home. PS confirmed C2 had been issued a 60-day notice to vacate that was issued on 5/18/21, though his parents were appealing this, with a court dated scheduled 7/8/21. PS stated C2's first aggression towards other clients happened in October 2020, when C2 shoved C4. After that incident C2 no longer shoved, but would hit other clients. PS stated there had been four or five incidents where C2 struck another client otherwise other incidents had been directed towards staff. PS confirmed the incidents occurred at all times throughout the day so there was no set pattern of when his behaviors could escalate. PS indicated C2 resided on the south side of the facility with C1 and C3, though C3 no longer stayed at the facility when C2 was there. C4, C5, and C6 resided on the north side of the facility and no longer would come over to the south side unless C2 was gone. PS confirmed the morning of 6/3/21, C2 did not actually lay hands on C1 though when his behavior started escalating, C2 did open C1's door while she was in bed. PS confirmed C1 was scared as she was wheelchair dependent and could not get out of bed to try to move or protect herself should C2 come into the room. PS stated currently C1 pretty much stayed in her room when C2 was home. C1 had an electric	W 285		

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W 285	Continued From page 21 wheelchair (w/c) so would come out of her room at times in the w/c but stayed close to where her room was so she could go in there quickly if needed. PS and LPN-A both stated staff had been doing their best to protect the other clients though were also fearful of getting hurt by C2 as he was a big guy (>6 feet tall) and strong, who's strength increased when his behaviors escalate. Upon follow-up interview with PS at 11:46 a.m., PS confirmed in the past they had initiated one-to-one staffing approximately three times a week for C2 but due to C2's aggressive behaviors many staff had left and now do not have enough staff to accommodate that. PS confirmed the facility was always staffed with a minimum of two staff (one on the north side and one on the south side) when C2 was present in the facility. PS stated that way if C2's behaviors started to escalate the north staff could assist with keeping the other clients safe. PS also stated they have advised C1 that if she was in her room and C2's behavior was escalating that if staff could get in the room with her they would, otherwise she should back her electric w/c into the door so C2 couldn't get it open. On 6/10/21, at 12:50 p.m. C1 was in her room watching TV seated in her electric w/c; the door to her room was closed and C2 was in the kitchen outside of the room. When interviewed at that time, C1 stated she did not really like living at the facility because of C2; he screams and throws things. C1 confirmed C2 had not ever thrown anything at her but was afraid he might. C1 stated last week being scared because of C2 and thought she was going to have to skip work. C1 stated C2 had opened her door but staff would not let him come in, and indicated C2 looked at her but he did not enter her room. C1 confirmed	W 285		

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when C2 was home she stayed in her room most of the time, and further stated maybe if C2 was sleeping she would come out but otherwise did not leave her room. C2 stated the staff want her to stay in her room for her protection so he does not hurt her. C1 confirmed she missed being in the other parts of the house and liked to eat her meals in the dining room, watch TV and be with the staff. C1 also stated staff told her to put her electric w/c against the door if C2 started screaming. C1 confirmed last week when C2 was screaming and opened her door she was in bed.

When interviewed on 6/10/21, at 1:10 p.m. DSP-A stated she is probably the only staff that C2 had not gone after and that multiple staff have left employment at the facility because of [C2]. DSP-A confirmed she usually worked overnights and occasionally picked up a few day shifts. DSP-A stated when she works the overnight shift alone being afraid should C2 get up during the night she may not be able to protect all of the clients from him. DSP-A further stated if she was in the bedroom with C1 on the south side of the facility trying to protect her, how would she protect C5 and C6 on the north side as they were also vulnerable. DSP-A confirmed there was one overnight she was working when she heard C2 get up out of bed and start breaking things in his room. DSP-A did not open the door to check on C2 an he never came out of his room and finally went back to sleep. DSP-A confirmed feeling fearful that night. DSP-A confirmed the incident with C2 during the early morning hours on 6/3/21, C2 had woken up at approximately 1:00 a.m. DSP-B was working that night and DSP-D came into work at 6:00 a.m. When asked how staff protect the other clients when C2's behaviors

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W 285	Continued From page 23 escalate, DSP-A stated they keep the other clients away from him. C1 stayed in her room and C3 did the same thing when he still resided in the facility. DSP-A stated C5 and C6 stay on the north side of the facility but C4 would still come over to the south side at times as he liked to sit in one of the recliners in the living room or go in the garage. DSP-A stated C4 was particular; if C2 went into the garage while C4 was in there, C4 would leave until C2 came out of the garage. DSP-A further stated if C2 got in C4's space, C4 would say, "no no no" and return to the north side of the facility. When interviewed on 6/10/21, at 1:29 p.m. DSP-D confirmed she worked the day shift on 6/3/21, and could hear C2's tablet volume turned up loud upon entering the facility. DSP-D stated she came in cautiously; there was broken glass in the hallway in front of C2's room because he had broken a globe and some picture frames. DSP-D went to look for DSP-B and found her outside talking to the police. DSP-B informed DSP-D that everything started up around 1:00 a.m. when she told C2 to turn his tablet down. DSP-B was pretty shaken up, and told DSP-D about C2 opening C1's door. DSP-B confronted C2; that was when he chased after her. DSP-B ran over to the north side of the facility and held the door shut while C2 tried to get in and subsequently called the police. DSP-D confirmed C2 was in the bathroom on the south side of the building when she arrived. After talking with DSP-B, DSP-D returned to the south side of the building to check on C2's whereabouts. At that time C2 was in his room. DSP-B had also called the PS, who came to the facility and checked in with C2 and he seemed ok. A short time later, PS again approached C2 and he went after her so they knew he still was	W 285		

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W 285	Continued From page 24 not calming down. C2 then came out to the kitchen; DSP-D went to check on him and he threw his tablet and started screaming. After a few minutes they checked on him again and that is when C2 threw the tablet again at DSP-D and chased DSP-D over to the north side of the facility. At that point, PS called guardian-A to come and pick C2 up from the facility. When guardian-A arrived at the facility, C2 went after him as well and was attempting to hit guardian-A with his shoe. Guardian-A eventually persuaded C2 to get into the car and kept C2 home until 6/6/21. DSP-D stated having to be so cautious around C2 as you never knew what he was going to do. DSP-D confirmed there was only one staff in the building during the night shift from 9:00 p.m. until 6:00 a.m. DSP-D stated on the overnight if C2 did get ahold of the staff and injure or knock them unconscious, wondered what he would do to the other clients. There was one episode during the overnight when C2 had gotten up during the night and started throwing things in his room. DSP-A was working that night and told DSP-D she thought DSP-D might come in and DSP-A might be laying on the floor as was scared of what he might do. DSP-D did not know if C2 had actually come out of his room that night. DSP-D confirmed the facility had lost staff due to C2's aggressive behaviors When interviewed on 6/10/21, at 2:55 p.m. licensed practical nurse (LPN)-A confirmed the facility only had one staff working on the overnight shift and that had been going on before C2 was admitted to the facility in September of 2020. LPN-A further stated being fearful for the overnight staff with C2 as she did not know how they could protect themselves and the other clients from him should his behaviors escalate.	W 285		

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When interviewed on 6/10/21, at 3:45 p.m. DSP-C stated the first time C2 came after her, he hit her in the face/neck area and left a big mark. The 2nd and 3rd time DSP-C was sitting at the dining room table; C2 came over and pulled her hair then pulled her down to the floor and started hitting and kicking her. About 30 minutes later after that episode ended another staff was in the dining area with DSP-C. When that staff left the area with another client, once they had exited around the corner he came after DSP-C again. After those episodes, C2 has attempted to hit and kick DSP-C and also had destroyed her cell phone. When C2 first arrived at the facility the behaviors were centered around food. C2 was constantly helping himself to other clients' food and when staff told him he could not do that he would escalate. One time DSP-C just turned the water off during C2's shower and he got upset - simple things. C2 had gone after C3 a couple times. When C2 first came to the facility he shook C4 when outside in the garage. DSP-C also thought C2 had thrown a vacuum cleaner one time that almost hit C6 but did not think he was actually throwing it at her. DSP-C confirmed only one staff was scheduled on the overnight shift. DSP-C stated when C2 first came to the facility, 99% of the time he slept through the night so one staff on the overnight shift was fine. Since the episode during the overnight shift on 6/3/21, DSP-C confirmed she would feel more comfortable if they had two staff on the overnight shift when C2 was there, to keep clients safe.

The policy titled, Administrative Review of Incidents, revised 8/20/18, indicated: 1. Individuals must not be subjected to abuse by anyone (including, but not limited to, facility staff,

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consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, other individuals receiving services, or themselves). 2. The QIDP (qualified intellectual disabilities professional) for the home will review incident reports and individual program notes to evaluate for patterns of incidents that could represent potential abuse or neglect as defined by Federal Regulation on a regular basis (monthly). 3. If there is a pattern noted among incidents of alleged abuse, accidents, behavior programs, psychoactive drug use, staff training, and adequacy of staffing levels that may suggest possible mistreatment, neglect or abuse of individuals, immediate action will be taken to protect the individual(s) in the home.

The Immediate Jeopardy began on 6/3/21, when C2 chased (DSP)-B to the north end of the building where DSP-B barricaded herself behind the door to the unit until law enforcement arrived, leaving C1 vulnerable to C2's aggressive behavior. The regional director was notified of the IJ 6/11/21, at 5:51 p.m.

The immediate jeopardy was removed on 6/14/21, at 2:26 p.m. when the facility ensured constant supervision of C2 on the overnight shift by adding an extra sleep staff to remain on the north side of the facility with a walkie talkie to enable staff on the south side to contact for help. Following the 6/3/21 incident with C2, the team completed a comprehensive assessment and identified the trigger that C2 does not like to be told "no", or what to do and was also very hard to redirect. That trigger was already identified in C2's behavior support plan. The team identified if it was not bothering others in the home that they would allow C2 to listen to electronics at whatever

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

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W 285	Continued From page 27 volume he desired. The team also was looking into setting the volume of the Kindle tablet at a lower volume locked with parental controls. The team will continue to comprehensively assess C2's behaviors following each situation and the functional behavior assessment and behavior support plan will be revised as new situations occur and new strategies are developed per input from the interdisciplinary team, behavioral analyst and staff feedback. The facility also arranged for additional staff training by the behavior analyst related to C2's aggressive behaviors. The training was scheduled for 6/24/21 from 12:30 p.m. - 2:30 p.m. and will also be recorded for staff who can not attend in person. Staff will be required to complete the training prior to their next scheduled shift. In addition, training in physical intervention alternatives and positive behavior supports was scheduled for staff on 7/1/21.	W 285		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Emailed on July 7, 2021

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

Re: Event ID: 8ZLI11

Dear Administrator:

The above facility survey was completed on June 14, 2021 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

Sincerely,

Kim Tyson

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

Minnesota Department of Health

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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 6/10/21 through 6/14/21, an abbreviated survey was completed to investigate complaint HG330005C (MN73502). The complaint was found to be substantiated. No licensing orders were issued. Your facility is in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).	5 000		

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

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W 000	INITIAL COMMENTS On 6/10/21 through 6/14/21, an abbreviated survey was conducted to investigate HG330005C. The facility was found NOT to be in compliance with the requirements of 42 CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). In addition, the Condition of Participation: Client Behavior & Facility Practices 42 CFR 483.450 was found not met. An extended survey in the the area of client protection was conducted. The following complaint was found to be substantiated: HG330005C (MN73502). Deficiency issued at W285. An Immediate Jeopardy (IJ) was identified at W285 on 6/11/21, at 5:51 p.m. The IJ began on 6/3/21, at approximately 5:43 a.m. when C2 was exhibiting dangerous behaviors by screaming, throwing objects, then charging after direct support professional (DSP)-B. DSP-B ran from the south side of the facility to the north side of the facility and barricaded herself behind the north entrance door until law enforcement arrived. The facility failed to develop and implement corrective actions, or modify interventions to prevent future occurrences. The facility's regional director was informed of the IJ situation on 6/11/21, at 5:51 p.m. The IJ was removed on 6/14/21, at 2:26 p.m. when the facility ensured constant supervision of C2 on the overnight shift by adding an extra staff, and arranged for additional staff	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 training related to C2's aggressive behaviors.	W 000		
W 266	CLIENT BEHAVIOR & FACILITY PRACTICES CFR(s): 483.450 The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.450 Client Behavior & Facility Practices, was not met. The facility failed to provide a safe environment for (C1, C4, C5, C6) due to the physically aggressive behaviors exhibited by C2. Staff are not able to manage C2's behaviors and have had to call local law enforcement when C2 is out of control. This resulted in an Immediate Jeopardy (IJ) for (C1, C4, C5, C6) due to the risk of physical abuse and placing all clients at risk of serious harm, injury or death. The IJ began on 6/3/21, at approximately 5:43 a.m. when C2 was exhibiting dangerous behaviors by screaming, throwing objects, then charging after direct support professional (DSP)-B. DSP-B ran from the south side of the facility to the north side of the facility and barricaded herself behind the north entrance door until law enforcement arrived. The facility failed to develop and implement corrective actions, or modify interventions to prevent future occurrences. The facility's regional director was informed of the IJ situation on 6/11/21, at 5:51 p.m. The IJ was removed on 6/14/21, at 2:26 p.m. when it could be verified the facility had	W 266		

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W 266	Continued From page 2 implemented corrective action. Findings include: See W285: The facility failed to provide a safe environment for (C1, C4, C5, C6) due to the physically aggressive behaviors exhibited by C2.	W 266		
W 285	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to provide a safe environment for (C1, C4, C5, C6) due to the physically aggressive behaviors exhibited by C2. Staff are not able to manage C2's behaviors and have had to call local law enforcement when C2 is out of control. This resulted in an Immediate Jeopardy (IJ) for (C1, C4, C5, C6) due to the risk of physical abuse and placing all clients at risk of serious harm, injury or death. The IJ began on 6/3/21, at approximately 5:43 a.m. when C2 was exhibiting dangerous behaviors by screaming, throwing objects, then charging after direct support professional (DSP)-B. DSP-B ran from the south side of the facility to the north side of the facility and barricaded herself behind the north entrance door until law enforcement arrived. The facility failed	W 285		

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W 285	Continued From page 3 to develop and implement corrective actions, or modify interventions to prevent future occurrences. The facility's regional director was informed of the IJ situation on 6/11/21, at 5:51 p.m. The IJ was removed on 6/14/21, at 2:26 p.m. when it could be verified the facility had implemented corrective action. Findings include: A facility incident report dated 6/3/21 identified C2 had a behavioral incident which resulted in C1 being unsupervised: On 6/3/21, at 5:30 a.m. (note: precursor to incident began approximately 1:00 a.m.) at approximately 1:00 a.m. C2 was in his bedroom and turned the Kindle tablet volume up to the maximum level. DSP-B opened C2's door and asked if he would please turn the volume down. C2 did not want to turn the volume down and put his blanket over his face. DSP-B stepped further into C2's room to turn the tablet down and C2 allowed it. Approximately two hours later, C2 again turned the volume up on the tablet. DSP-B again opened C2's door and asked that he please turn it down as other clients were trying to sleep. C2 again put his blanket over his head though allowed DSP-B to turn the volume down. At approximately 5:30 a.m., DSP-B was finishing assisting C1 with using the commode in her room. C2 again had turned the volume up loud on his tablet. DSP-B opened C2's door and asked if he could turn the volume down a bit as C1 was trying to go back to sleep. C2 got up off his bed and started yelling (in his dinosaur voice) and coming after DSP-B. DSP-B walked halfway down the southside hallway and was still able to visualize C2. C2 came out of his room then	W 285		

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W 285	Continued From page 4 proceeded to open C1's bedroom door. DSP-B told C2 that was not his room; he then came charging after DSP-D. C2 went into his room and started to throw and break things. DSP-B called the police at approximately 5:43 a.m. due to C2 being agitated and throwing items in his room. The police arrived, however, C2 did not appear to be agitated at that time. Staff called the PS around 5:59 a.m.; PS arrived at 6:02 a.m. Upon arrival she walked past C2's bedroom door, there was broken glass and objects on the floor. C2 was sitting on his bed; SP said hi and good morning, then pulled C2's door shut and went to talk to the police. The police stated they had no interaction with C2 as he was not agitated when they arrived and they then left. At 6:10 a.m., C2 was standing in the hallway next to the entryway door. C2 stated to yell and reach for PS. PS shut the door and C2 proceeded to hit the door, threw the Kindle tablet, and knocked over chairs. At 6:30 a.m., guardian-A was called and agreed to come to the facility. Staff did visual checks on C2 every 15 minutes. Every time C2 would visualize staff he would become agitated all over again. Guardian-A arrived at the facility at approximately 7:05 a.m. Guardian-A talked with C2 but then C2 began to yell and started to hit guardian-A. C2 chased guardian-A and PS outside. C2 proceeded to attempt to hit guardian-A and also hit and kicked cars that were nearby. C2 left the premises with guardian-A at approximately 7:30 a.m., with a plan to return to the facility on 6/6/21. When C2 went outside, staff were able to check on C1. C1 indicated she was scared due to hearing C2 yelling, throwing and breaking things. When interviewed on 6/11/21, at 8:30 a.m. DSP-B confirmed having worked the night shift from 6/2/21, into the morning of 6/3/21. DSP-B stated	W 285		

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W 285	Continued From page 5 C2 was awake pretty much all night long with behaviors starting at approximately 1:30 a.m. C2 had turned the volume on his tablet up to the maximum level. DSP-B asked C2 to turn the volume down and he put his blanket over his head. When DSP-B then asked if she could turn down the volume, C2 did not respond though allowed DSP-B to turn down the volume. A couple hours later the same thing happened and C2 allowed DSP-B to turn the volume down on his tablet. At approximately 5:00 a.m., C1 called for DSP-B, and asked to use the commode in her room. DSP-B stated it was quiet in C2's room so she assumed he was asleep. Once DSP-B had gotten C1 back to bed and exited her room, the volume on C2's tablet instantly increased to the maximum level. DSP-B opened C2's door and asked him again to turn the volume down; he then charged after her. DSP-B started going down the south hall; C2 went back in his room and started throwing things at DSP-B and pulling things off the wall and throwing down the hall at DSP-B. Once he finished throwing things, he went back into his room. DSP-B waited in the hallway. Eventually, C2 came out to the hallway still screaming, then opened C1's bedroom door like he was going to enter the room. DSP-B told C2 it was C1's room, and he could not go in there, that is when he came charging down the hallway at DSP-B screaming. DSP-B then went to the north unit and shut the door, holding the door shut while C2 pulled and banged on the door screaming. DSP-B stated when C2 would stop pulling on the door she would peek out; he was still there and would charge the door and start pulling again. After doing this a couple times DSP-B called the police because she knew she could not get to C1 safely and also knew C1 was awake and hearing	W 285		

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W 285	Continued From page 6 C2 screaming. DSP-B confirmed remaining on the north unit until the police arrived which left C1 unsupervised. The police stated they had visualized C2 in the south entryway when they arrived. The police did not enter the facility and advised DSP-B they were unable to detain C2 and recommended DSP-B call the PS. The police remained outside the facility until the PS arrived. DSP-B stated she remained at the facility until guardian-A arrived because C2 was not calming down and staff could not get to C1. Guardian-A arrived at approximately 7:45 a.m.; once guardian-A got C2 into the garage, DSP-B was able to safely get to C1's room and get her up and ready for work. DSP-B stated C1 was really shaken up when she got to her. C1 had indicated when no one came she was afraid that C2 would come into her room and get to her. C1 told DSP-B that when C2 became quiet she thought she was safe, but then when he started screaming she got scared all over again. DSP-B confirmed following that episode being uncomfortable staying alone at night with C2 in the facility. DSP-B stated, "Honestly after that I stay on the north side but do checks on C1 throughout the night. I've told [PS] I'm uncomfortable. Before this episode he would sleep most of the time and might get up and use the bathroom but would go back to bed." C2's undated Service Recipient Information Cover Sheet indicated diagnoses including: autism spectrum disorder with intellectual disability (neurodevelopment disorder that causes a wide range of impairments in social communication and restricted and repetitive behaviors, with limited intellectual functioning and adaptive behavior), metabolic disorder (group of health conditions leading to increased risk of	W 285		

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W 285	Continued From page 7 heart diseases and related problems), and epilepsy (seizure disorder). C2's Behavior Action Plan dated 1/15/21, identified physical aggression including but not limited to C2 pushing staff, grabbing his peers, shaking his peers, pushing staff into the wall, attempting to kick staff, kicking staff, hitting staff, and/or ripping staff's clothing. The plan also identified invading other's space or violating boundaries including but not limited to C2 following his peers around too closely, touching peers clothing when sitting too closely to them, talking to his peers too closely (within one inch from their face), and/or going into peer's room and taking their items without their permission. Proactive interventions when behavior was not being demonstrated directed staff to keep C2 engaged in a preferred activity or talk about the things he likes. Staff were to avoid giving demands or bringing up things that C2 didn't like to talk about. Staff were to avoid telling C2 "no", and should use first then statements. "C2 first let's put your coat and hat on then we can go on a van ride." Staff could also use statement that indicate when C2 could access something that he wanted. Staff were to provide as much choice in C2's day as possible and allow him to have as much control over his environment as possible. Staff were also directed to utilize a schedule to structure C2's time and avoid boredom. Staff were also to give C2 one-to-one time, build rapport, and give C2 behavior specific praise for behaviors they wanted to see more of. Reactive interventions to the physical aggression directed staff to discontinue prompting at this level as verbal de-escalation was not likely to be effective after the initial prompt to stop. Staff should give neutral attention ignoring this behavior. Staff	W 285		

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W 285	Continued From page 8 should not tell C2 that he is hurting anyone or that he is being inappropriate as this is negative attention may make it more probable that this behavior will occur again in the future. Staff should follow the steps as taught in physical interventions alternatives (PIA-Techniques to protect staff and others-defensive physical maneuvers to keep staff and others from being injured when someone becomes aggressive. C2's Risk Assessment Detail last modified 4/4/21, indicated C2 likes to make noises such as playing with toys, TV/radio up loud, make bodily noises, and to invade others personal space. This may provoke others behaviors towards C2. C2's Functional Behavior Assessment dated 12/15/20, indicated C2's physical aggression behavior was classified as severe. C2 had been observed to display behaviors that have the ability to significantly injure another individual. From September 2nd, 2020 to December 15th, 2020, C2 had engaged in a total of 19 instances of physical aggression. This information was gathered from staff shift notes. C1's undated Service Recipient Information Cover Sheet indicated diagnoses including: mild intellectual disability, cerebral palsy (group of disorders that affect movement, muscle tone, balance, and posture), bilateral spastic hemiparesis (both sides of the body is afflicted with weakness, but is not paralyzed), and seizure disorder. C1's Risk Assessment Detail dated 6/3/20, indicated C1 would be unable to defend herself against abuse due to her physical limitations.	W 285		

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C4's undated Service Recipient Information Cover Sheet indicated diagnoses including: moderate intellectual disability and bipolar affective disorder (mental health condition that causes extreme mood swings).

C4's Risk Assessment Detail dated 6/14/21, indicated it was unclear whether C4 knew what to do during an abusive situation.

C5's undated Service Recipient Information Cover Sheet indicated diagnoses including: severe intellectual disorder, Down's syndrome, and dementia.

C5's Risk Assessment Detail dated 4/6/21, indicated due to physical limitations, C5 is unable to defend herself against abuse.

C6's undated Service Recipient Information Cover Sheet indicated diagnoses including: profound intellectual disability, cerebral palsy, and seizure disorder.

C6's Risk Assessment Detail dated 5/19/21, indicated due to C6's size, disability, and strength level, she would be unable to defend herself against abuse.

C2's incident reports indicated multiple behavioral incident with other clients or staff:

- 10/17/20 at 3:30 p.m. C2 became agitated after being told by staff that he couldn't go outside. When C4, who was able to go outside by himself, attempted to leave the house, C2 grabbed C4 around the arms, shook C4 and started screaming. Staff directed C2 to release C4; when C2 released C4 he shoved C4 in the process. C2

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then grabeed direct support professional (DSP)-E, who was able to get away. C2 then chased DSP-E to the south side kitchen. C2 then attempted to grab C6, but staff intervened before he could get to her.

- 11/17/20, at 8:15 p.m. DSP-E found C2 in the basement and asked C2 to go upstairs so they could finish the med pass and putting other clients to bed. C2 became upset and would not listen to DSP-E. DSP-E went to get help from DSP-F; C2 would not listen to either staff. DSP-F approached C2 and he hit her. C2 then began screaming and started to chase DSP-E; C2 grabbed her shirt and scratched her. C2 would not let go of DSP-E's shirt and the shirt ended up ripping when DSP-E tried to get away and the staff fell to the floor. C2 then laid down on the floor and would not get up. Staff called the program supervisor (PS) to come in for assistance. The PS came to the facility and talked to C2 who eventually got up, called his parents, then went to bed.

- 12/8/20, at 3:05 p.m. C2 slapped DSP-C across the left side of face leaving a big red mark. DSP-C stated that C2 did not want to take a shower earlier that morning because he was watching TV and was going to wait until later in the afternoon to do it. DSP-C stated around 3:05 p.m. she asked C2 to take his shower. C2 then charged at DSP-C, slapped her and went to his room and slammed the door.

- 12/9/20, at 2:00 p.m. DSP-C went to let C2 know it was someone else's turn for the TV and that the movie he was watching was not his and needed to return it to the other client. C2 threw the remote at the TV, got up and threw the dining

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room chair on the ground, pushed everything on the table to the ground and then came running after DSP-C. C2 hit DSP-C on the neck/back twice and pushed her up against the wall twice in a row.

- 12/9/20, at 4:30 p.m. C2 ran towards DSP-F and scratched, hit, kicked, pushed, and pulled DSP-F to the ground along with C2. C2 broke DSP-F's glasses then laid on the floor with his hands on his face. DSP-F made sure C2 was not hurt and let him lay on the floor to calm down as C2 did not want to get up.

- 12/16/20, at 3:25 p.m. the program supervisor (PS) heard C4 tell C2 "No". PS observed C2 bend over in front of C4, who was seated in a recliner, and reach for something. C4 kept telling C2, "No." PS attempted to verbally redirect C2. C2 came at PS and pushed her past the Christmas tree, then pulled on PS's shirt sleeve. PS asked C2 to let go and he did. C2 then kicked the Christmas tree, looked at PS, then went over to the recliner where C4 was sitting and slapped C4 on the stomach.

- 12/28/21, at 7:30 p.m. C2 went into C3's bedroom while the door was closed and started to take a DVD that was not his. C3 confronted C2 who then hit C3 in the chest leaving a red mark. A short time later C2 came into the kitchen and DSP-F told him she would get him a snack in a little bit. C2 then came around the kitchen corner and came after DSP-F and started hitting her. DSP-F blocked themselves from C2's hits and C2 then fell to the floor. While on the floor, DSP-F put their hands out to keep C2 from getting up because another client was sitting at the table where he was positioned on the floor. C2

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W 285	Continued From page 12 grabbed the vacuum cleaner an swung it next to the client sitting at the table but he did not hit them. - 3/23/21, at 5:20 p.m. C2 assisted DSP-E for a short time with preparing biscuit dough for supper. C2 then went to go watch TV while DSP-E continued preparing supper. DSP-H was on the north side of the facility. While DSP-E continued to prepare supper, C2 was able to get on the staff laptop at the desk. DSP-E attempted to distract C2 by asking him to help more with supper. DSP-H came over to the south side of the facility and also attempted to get C2 off laptop. Staff had informed the PS at approximately 5:20 p.m. that C2 had the laptop for about 30 minutes and was not getting off of it and attempted distractions including supper, calling dad, and a bath. PS came to the facility to assist staff with obtaining the laptop. When PS arrived C2 was sitting at the desk watching YouTube on the laptop with his supper next to him untouched. PS asked C2 to move to the kitchen table to eat supper; C2 did not look up until PS moved his plate a bit, then went right back to the laptop. PS lifted up the laptop by the corner saying to him lets eat supper. C2 stood up, yelled, picked up his plate and dumped it over his head. C2 then tossed the kitchen table chair, grabbed staff's backpack and threw it into the kitchen at DSP-E. C2 then went after DSP-E and pushed her into the dishwasher, pulled her hair, and broke her glasses. PS then got in between DSP-E and C2. C2 grabbed PS by the jacket and pulled PS to him. PS noticed a knife nearby and went to grab it to move it out of the way; C2 grabbed the knife as well. PS was able to get the knife away from C2 and safely put it in the sink. C2 then kicked PS multiple times in the legs,	W 285		

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grabbed PS again, and pulled PS to the ground kicking her in the legs. PS stood up, C2 then grabbed the backpack and threw it, then grabbed PS again and attempted to pull PS down; PS then hit her left eye on the counter. PS was able to get away and C2 then sat in the middle of the kitchen floor. At approximately 6:50 p.m., DSP-H texted PS that C2 had attacked him at the desk. PS called the program director (PD) to see if she would go with her to the facility to assist with C2 at that time. Prior to PS and PD's arrival, DSP-H was sitting at the desk looking at the medication that just came in from the pharmacy and C2 came out of his room. DSP-H put the medication down and looked up at C2 to talk to him and C2 started running at DSP-H. C2 attempted to take DSP-H's phone out of his hand, then hit DSP-H's glasses off of his face. C2 then sat down on the floor and started kicking DSP-H. When DSP-H got up to retrieve the glasses, C2 grabbed the glasses and threw them into the entryway. PS arrived at the facility at 7:00 p.m. and C2 was seated in front of the southside basement door on the floor. PS asked C2 why he was sitting on the floor and C2 raised his hand. PS took C2's hand and C2 attempted to pull PS down to the floor; PS pulled away. PD arrived and tried the same thing and C2 tried to pull PD down as well. PD talked with C2 and had other staff open the front door so C2 could get to his stuffed animal. PD was able to get C2 to pick up the recycling he had thrown and PS gave C2 his stuffed animal. C2 took his medications, snack and seemed ok.

- 4/7/21, at 6:30 p.m. DSP-E was assisting another staff with a client on the north side of the facility. Upon return to the south side of the facility, DSP-E observed C2 enter his bedroom and slam the door. C3 indicated C2 had entered

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C3's bedroom when C3 was not in there, and took one of C3's movies. C3 tried to take the movie away from C2 and told him it was not his. C2 then hit C3 with a closed fist on his right side and also hit C3 in the back with C3's bedroom door while attempting to close it to keep C3 out of his room. DSP-E checked C3 for injuries and C3 had two red marks on his right side and on his left side of his back.

- 4/8/21, at 6:00 p.m. DSP-I observed C2 take a DVD from the living room that belonged to another client, to his room. DSP-I followed C2 to his room; C2 was seated down at the head of his bed. DSP-I took hold of the DVD and advised C2 that it belonged to another client and he did not have permission to take it. DSP-I attempted to take the DVD from C2, but C2 would not let go. DSP-I again advised C2 that he was taking the DVD back and pulled it from C2's hands. C2 then raised his hands and attempted to push DSP-I as he backed away from him. Once at the foot of the bed, DSP-I turned to exit the room; C2 grabbed DSP-I by the back of the shirt and yanked them back causing DSP-I to lose his balance. DSP-I fell to the floor on his back and his head slightly hit the wall trim. C2 then grabbed the cords of his TV and DVD player and yanked on them. C2 then reached for his Tonka truck and threw it towards DSP-I as they were exiting C2's bedroom and shutting the door. DSP-I kept C2's door closed until C2 was finished throwing things, and checked on the other clients. DSP-I then checked on C2 to see if he had calmed down. C2 was seated at the head of the bed and immediately grabbed his radio and threw it towards DSP-I who again shut the door until he stopped throwing things.

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W 285	Continued From page 15 - 4/23/21, at 11:45 a.m. DSP-D was getting lunch ready for the clients and asked C2 to sit at the dining room table. DSP-D asked C2 to take his medication and set a glass of milk in front of him. DSP-D retrieved C2's plate, and when returning to the table C2 threw his milk and started to go after DSP-D. DSP-D exited through the living room to the southside hallway. C2 entered the southside hallway from the other direction; at that time C3 was coming around the corner. C2 then struck C3 on the head. C2 then entered his bedroom and started throwing things. At approximately 12:30 p.m., DSP-C went into the kitchen to get something out of the refrigerator for another client. C2 came up behind DSP-C, cornered her in the kitchen, and began hitting her on the back and shoulders. C2 then reached for DSP-C's cell phone, which was in her sweatshirt pocket. DSP-C was able to get away from C2 and went into another client's room and closed the door. C2 then started throwing anything he could find. - 5/4/21, at 11:00 a.m. DSP-I was assisting C2 with a shower and morning grooming. While assisting C2 with shaving, and while putting shaving cream on C2's face, C2 used one arm to push DSP-I away then grabbed DSP-I by the neck of the shirt leaving a scratch on staff's chest from neck to cleavage area. C2 then threw himself to the floor trying to pull DSP-I down with him. Once C2 lost his grip on staff's shirt he started kicking his feet and grabbing for things. DSP-I then left the bathroom and shut the door while C2 continued to throw things. Once C2 had calmed, DSP-I opened the door and C2 had gotten back in the shower. DSP-I advised C2 if he was ready to get up to shut the water off, then get out and staff stepped back out just in case.	W 285		

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After DSP-I heard the water shut off, she went back into the bathroom to assist C2 with drying off and getting dressed. C2 started yelling again and charged the door slamming it shut, then started hitting, throwing and breaking things. DSP-I let C2 be at that point and C2 eventually dried and dressed himself then went to his bedroom.

- 5/5/21, at 4:00 a.m. DSP-A heard C2 yelling deeply and loudly in his room, then could be heard throwing things in his room. This lasted approximately 10 minutes though C2 did not leave his room during that time. At 7:30 a.m., C2 exited his room to use the bathroom, then returned to his room. At 8:00 a.m. DSP-A entered C2's room to assist with changing his clothes as he had been incontinent of urine. At 8:15 a.m., day staff - DSP-I took over supervision for the south side of the facility. C2 took his medications, ate breakfast, then returned to his room. At approximately 8:40 a.m., C2 charged at DSP-I as she was walking past his bedroom door. DSP-I attempted to get C2 into his bedroom so she could shut his door. C2 grabbed DSP-I's shirt and pushed her hard into C1's bedroom door (located to the right of C2's doorway). C2 then fell to the floor and pulled DSP-I down with him. DSP-I was able to get up and back away from C2. C2 sat on the floor screaming and kicking before sitting in silence in front of C1's door for approximately 30 minutes. DSP-I informed the PS of the situation and also to inform PS that she could not safely get to C1 to administer the clients medications or assist them with toileting. Shortly after that, C2 got up and sat at the dining room table and DSP-I assisted him. When C2 got up to use the bathroom and the area was safe, DSP-I was able to enter C1's room and assist her

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W 285	Continued From page 17 with morning cares. When C2 exited the bathroom, he observed DSP-D in the front entryway and charged after her. DSP-D barricaded herself behind the door entering the north side of the building and held it shut before C2 could get to her. C2 proceeded to throw himself at the north entrance door, beating on the walls and the door attempting to get to DSP-D. While DSP-D was holding the door shut, licensed practical nurse (LPN)-A had come up from the basement and also helped DSP-D to hold the door shut. Staff could not approach C2 safely and LPN-A subsequently called law enforcement at approximately 9:30 a.m. Staff met the police outside when they arrived at 9:35 a.m. Shortly after the two police arrived onsite, DSP-I heard them talking with C2. C2 went to punch one of the officers; the officers then each grabbed one of C2's arms and brought C2 down to the floor. C2 continued to be combative and screaming for 30+ minutes before the ambulance arrived. Once the ambulance arrived, the EMT (emergency medical technician) gave C2 an injection of Zyprexa (an antipsychotic medication) 10 milligrams (mg) in his upper left arm. C2 then calmed down a few minutes later. The paramedics used restraints on C2 while transporting to the ER at approximately 10:00 a.m. Once at the ER, C2 allowed the staff there to complete vital signs. The ER physician was asked about a 72 hour emergency hold for C2's safety and also for the safety of the other clients at the facility. The physician stated that sometimes they would not do that unless he was suicidal or something was psychologically wrong with him. C2's parents arrived at the ER as well. C2 was still restrained in the bed. Blood work and scans were performed and results of the scan showed C2 was moderately full of bowel and needed a bowel clean out. C2 was released	W 285		

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W 285	Continued From page 18 from the hospital ER and went to his parent's home. Parent's indicated they would complete the clean out. - 5/21/21, at 10:00 a.m. (note: precursor to incident began at approximately 8:30 a.m.) at approximately 8:30 a.m., overnight staff DSP-B, walked over to the north side of the facility to gather her belongings prior to leaving her shift; C2 followed her. C2 sat down in one of the recliners on the north side and started to utilize his Kindle tablet. DSP-B stated to C2, "Hey buddy, can't be over here." C2 ignored DSP-B and continued to play with his Kindle. DSP-B then stated, "Can't be over here, let's go over to the other side." C2 then walked over to the south side of the facility and slammed the doors. At 10:00 a.m. DSP-F went to C2's room and asked if he wanted to take a shower. C2 nodded yes and DSP-F had him pick out his clothes. DSP-F and C2 then went into the southside bathroom where DSP-F assisted C2 with washing his hair and his body. DSP-F then started to put shaving gel on his face. C2 did not say anything to staff, but when they started to put the gel on his face he hit DSP-F in the chest. C2 then started to scream and grabbed DSP-F. The floor was wet and when he pulled on staff, C2 slipped and fell on the floor backwards bringing DSP-F down with him while still holding onto her. DSP-F hit her right knee on the floor. When DSP-F got up off the floor, C2 grabbed the trash can and threw it. DSP-F left the bathroom and shut the door, standing outside the door in the hallway for approximately two minutes, then popped her head inside the door and C2 was back in the shower. DSP-F left C2 alone for five minutes while standing outside of the door, and the put his clothes and towel on the counter. At that time	W 285		

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W 285	Continued From page 19 she also told C2 these items were in the bathroom on the counter and that he could shut the water off when finished. C2 did not answer or respond. DSP-F then walked to the north side of the facility and at that time heard the water shut off. DSP-F checked on C2 10-15 minutes later and he was dressed and in the garage with his Kindle tablet. While C2 was in the garage, DSP-F went to clean up the bathroom. C2 continued to have the dark/black eyes look (which was an indicator of potential explosive aggressive interfering behaviors) and was engaged in playing on his Kindle tablet. DSP-F continued to do visual checks on C2 and he remained in the garage using his Kindle tablet. At noon, DSP-F walked to the doorway to the garage and let C2 know his food was ready for lunch. C2 got up and came around the van walking towards staff, his eyes remained dark/black and he threw the Kindle towards DSP-F. DSP-F shut the door and walked to the entryway leading into the north side of the facility an heard C2 come inside an sit down at the table. After approximately 15 minutes, DSP-F went to do a visual check on C2 and he had eaten his lunch, put his plate in the sink, and was back in the garage on the Kindle tablet. - 6/7/21, at 7:55 a.m. DSP-C had started giving C2 his Miralax (a laxative) mixed with liquid for his "clean out." When DSP-C went to administer the third dosage, (C2's bedroom doorway), he pushed DSP-C and did his dinosaur voice and started to run towards DSP-C and tried to grab her. As DSP-C was exiting to the northside entryway, she heard and saw C2 go into the south bathroom and slammed the door. DSP-D checked on C2 approximately 30 minutes later. As DSP-D opened the entryway door, C2 started	W 285		

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running towards her yelling. As DSP-D was closing the entryway door, she heard and visualized C2 go into the south bathroom. After 10 minutes, DSP-D checked on C2 again and he was in his bedroom asleep at that time.

When interviewed on 6/10/21, at 10:50 a.m. PS confirmed C2 had aggressive behaviors and had a couple incidents where he hit C3. C3's guardian-B did not think C3 was safe when C2 was at the facility so she took him home. PS confirmed C2 had been issued a 60-day notice to vacate that was issued on 5/18/21, though his parents were appealing this, with a court dated scheduled 7/8/21. PS stated C2's first aggression towards other clients happened in October 2020, when C2 shoved C4. After that incident C2 no longer shoved, but would hit other clients. PS stated there had been four or five incidents where C2 struck another client otherwise other incidents had been directed towards staff. PS confirmed the incidents occurred at all times throughout the day so there was no set pattern of when his behaviors could escalate. PS indicated C2 resided on the south side of the facility with C1 and C3, though C3 no longer stayed at the facility when C2 was there. C4, C5, and C6 resided on the north side of the facility and no longer would come over to the south side unless C2 was gone. PS confirmed the morning of 6/3/21, C2 did not actually lay hands on C1 though when his behavior started escalating, C2 did open C1's door while she was in bed. PS confirmed
C1 was scared as she was wheelchair dependent and could not get out of bed to try to move or protect herself should C2 come into the room. PS stated currently C1 pretty much stayed in her room when C2 was home. C1 had an electric

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W 285	Continued From page 21 wheelchair (w/c) so would come out of her room at times in the w/c but stayed close to where her room was so she could go in there quickly if needed. PS and LPN-A both stated staff had been doing their best to protect the other clients though were also fearful of getting hurt by C2 as he was a big guy (>6 feet tall) and strong, who's strength increased when his behaviors escalate. Upon follow-up interview with PS at 11:46 a.m., PS confirmed in the past they had initiated one-to-one staffing approximately three times a week for C2 but due to C2's aggressive behaviors many staff had left and now do not have enough staff to accommodate that. PS confirmed the facility was always staffed with a minimum of two staff (one on the north side and one on the south side) when C2 was present in the facility. PS stated that way if C2's behaviors started to escalate the north staff could assist with keeping the other clients safe. PS also stated they have advised C1 that if she was in her room and C2's behavior was escalating that if staff could get in the room with her they would, otherwise she should back her electric w/c into the door so C2 couldn't get it open. On 6/10/21, at 12:50 p.m. C1 was in her room watching TV seated in her electric w/c; the door to her room was closed and C2 was in the kitchen outside of the room. When interviewed at that time, C1 stated she did not really like living at the facility because of C2; he screams and throws things. C1 confirmed C2 had not ever thrown anything at her but was afraid he might. C1 stated last week being scared because of C2 and thought she was going to have to skip work. C1 stated C2 had opened her door but staff would not let him come in, and indicated C2 looked at her but he did not enter her room. C1 confirmed	W 285		

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when C2 was home she stayed in her room most of the time, and further stated maybe if C2 was sleeping she would come out but otherwise did not leave her room. C2 stated the staff want her to stay in her room for her protection so he does not hurt her. C1 confirmed she missed being in the other parts of the house and liked to eat her meals in the dining room, watch TV and be with the staff. C1 also stated staff told her to put her electric w/c against the door if C2 started screaming. C1 confirmed last week when C2 was screaming and opened her door she was in bed.

When interviewed on 6/10/21, at 1:10 p.m. DSP-A stated she is probably the only staff that C2 had not gone after and that multiple staff have left employment at the facility because of [C2]. DSP-A confirmed she usually worked overnights and occasionally picked up a few day shifts. DSP-A stated when she works the overnight shift alone being afraid should C2 get up during the night she may not be able to protect all of the clients from him. DSP-A further stated if she was in the bedroom with C1 on the south side of the facility trying to protect her, how would she protect C5 and C6 on the north side as they were also vulnerable. DSP-A confirmed there was one overnight she was working when she heard C2 get up out of bed and start breaking things in his room. DSP-A did not open the door to check on C2 an he never came out of his room and finally went back to sleep. DSP-A confirmed feeling fearful that night. DSP-A confirmed the incident with C2 during the early morning hours on 6/3/21, C2 had woken up at approximately 1:00 a.m. DSP-B was working that night and DSP-D came into work at 6:00 a.m. When asked how staff protect the other clients when C2's behaviors

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escalate, DSP-A stated they keep the other clients away from him. C1 stayed in her room and C3 did the same thing when he still resided in the facility. DSP-A stated C5 and C6 stay on the north side of the facility but C4 would still come over to the south side at times as he liked to sit in one of the recliners in the living room or go in the garage. DSP-A stated C4 was particular; if C2 went into the garage while C4 was in there, C4 would leave until C2 came out of the garage. DSP-A further stated if C2 got in C4's space, C4 would say, "no no no" and return to the north side of the facility.

When interviewed on 6/10/21, at 1:29 p.m. DSP-D confirmed she worked the day shift on 6/3/21, and could hear C2's tablet volume turned up loud upon entering the facility. DSP-D stated she came in cautiously; there was broken glass in the hallway in front of C2's room because he had broken a globe and some picture frames. DSP-D went to look for DSP-B and found her outside talking to the police. DSP-B informed DSP-D that everything started up around 1:00 a.m. when she told C2 to turn his tablet down. DSP-B was pretty shaken up, and told DSP-D about C2 opening C1's door. DSP-B confronted C2; that was when he chased after her. DSP-B ran over to the north side of the facility and held the door shut while C2 tried to get in and subsequently called the police. DSP-D confirmed C2 was in the bathroom on the south side of the building when she arrived. After talking with DSP-B, DSP-D returned to the south side of the building to check on C2's whereabouts. At that time C2 was in his room. DSP-B had also called the PS, who came to the facility and checked in with C2 and he seemed ok. A short time later, PS again approached C2 and he went after her so they knew he still was

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not calming down. C2 then came out to the kitchen; DSP-D went to check on him and he threw his tablet and started screaming. After a few minutes they checked on him again and that is when C2 threw the tablet again at DSP-D and chased DSP-D over to the north side of the facility. At that point, PS called guardian-A to come and pick C2 up from the facility. When guardian-A arrived at the facility, C2 went after him as well and was attempting to hit guardian-A with his shoe. Guardian-A eventually persuaded C2 to get into the car and kept C2 home until 6/6/21. DSP-D stated having to be so cautious around C2 as you never knew what he was going to do. DSP-D confirmed there was only one staff in the building during the night shift from 9:00 p.m. until 6:00 a.m. DSP-D stated on the overnight if C2 did get ahold of the staff and injure or knock them unconscious, wondered what he would do to the other clients. There was one episode during the overnight when C2 had gotten up during the night and started throwing things in his room. DSP-A was working that night and told DSP-D she thought DSP-D might come in and DSP-A might be laying on the floor as was scared of what he might do. DSP-D did not know if C2 had actually come out of his room that night. DSP-D confirmed the facility had lost staff due to C2's aggressive behaviors

When interviewed on 6/10/21, at 2:55 p.m. licensed practical nurse (LPN)-A confirmed the facility only had one staff working on the overnight shift and that had been going on before C2 was admitted to the facility in September of 2020. LPN-A further stated being fearful for the overnight staff with C2 as she did not know how they could protect themselves and the other clients from him should his behaviors escalate.

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W 285	Continued From page 25 When interviewed on 6/10/21, at 3:45 p.m. DSP-C stated the first time C2 came after her, he hit her in the face/neck area and left a big mark. The 2nd and 3rd time DSP-C was sitting at the dining room table; C2 came over and pulled her hair then pulled her down to the floor and started hitting and kicking her. About 30 minutes later after that episode ended another staff was in the dining area with DSP-C. When that staff left the area with another client, once they had exited around the corner he came after DSP-C again. After those episodes, C2 has attempted to hit and kick DSP-C and also had destroyed her cell phone. When C2 first arrived at the facility the behaviors were centered around food. C2 was constantly helping himself to other clients' food and when staff told him he could not do that he would escalate. One time DSP-C just turned the water off during C2's shower and he got upset - simple things. C2 had gone after C3 a couple times. When C2 first came to the facility he shook C4 when outside in the garage. DSP-C also thought C2 had thrown a vacuum cleaner one time that almost hit C6 but did not think he was actually throwing it at her. DSP-C confirmed only one staff was scheduled on the overnight shift. DSP-C stated when C2 first came to the facility, 99% of the time he slept through the night so one staff on the overnight shift was fine. Since the episode during the overnight shift on 6/3/21, DSP-C confirmed she would feel more comfortable if they had two staff on the overnight shift when C2 was there, to keep clients safe. The policy titled, Administrative Review of Incidents, revised 8/20/18, indicated: 1. Individuals must not be subjected to abuse by anyone (including, but not limited to, facility staff,	W 285		

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 06/14/2021

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

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W 285	Continued From page 26 consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, other individuals receiving services, or themselves). 2. The QIDP (qualified intellectual disabilities professional) for the home will review incident reports and individual program notes to evaluate for patterns of incidents that could represent potential abuse or neglect as defined by Federal Regulation on a regular basis (monthly). 3. If there is a pattern noted among incidents of alleged abuse, accidents, behavior programs, psychoactive drug use, staff training, and adequacy of staffing levels that may suggest possible mistreatment, neglect or abuse of individuals, immediate action will be taken to protect the individual(s) in the home. The Immediate Jeopardy began on 6/3/21, when C2 chased (DSP)-B to the north end of the building where DSP-B barricaded herself behind the door to the unit until law enforcement arrived, leaving C1 vulnerable to C2's aggressive behavior. The regional director was notified of the IJ 6/11/21, at 5:51 p.m. The immediate jeopardy was removed on 6/14/21, at 2:26 p.m. when the facility ensured constant supervision of C2 on the overnight shift by adding an extra sleep staff to remain on the north side of the facility with a walkie talkie to enable staff on the south side to contact for help. Following the 6/3/21 incident with C2, the team completed a comprehensive assessment and identified the trigger that C2 does not like to be told "no", or what to do and was also very hard to redirect. That trigger was already identified in C2's behavior support plan. The team identified if it was not bothering others in the home that they would allow C2 to listen to electronics at whatever	W 285		

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 285	Continued From page 27 volume he desired. The team also was looking into setting the volume of the Kindle tablet at a lower volume locked with parental controls. The team will continue to comprehensively assess C2's behaviors following each situation and the functional behavior assessment and behavior support plan will be revised as new situations occur and new strategies are developed per input from the interdisciplinary team, behavioral analyst and staff feedback. The facility also arranged for additional staff training by the behavior analyst related to C2's aggressive behaviors. The training was scheduled for 6/24/21 from 12:30 p.m. - 2:30 p.m. and will also be recorded for staff who can not attend in person. Staff will be required to complete the training prior to their next scheduled shift. In addition, training in physical intervention alternatives and positive behavior supports was scheduled for staff on 7/1/21.	W 285		