



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

December 12, 2025

Administrator  
Living Well Central  
1555 Central Avenue Southwest  
Cambridge, MN 55008

Re: Enclosed Re-inspection Results - Event ID: 45JS12

Dear Administrator:

On November 24, 2025 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a re-inspection of your facility, to determine correction of orders found on the survey completed on October 10, 2025. At this time these correction orders were found corrected.

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

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Compliance Analyst | Federal Enforcement  
Health Regulation Division  
Minnesota Department of Health  
[Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)  
Office: 651-201-4112



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December 12, 2025

Administrator  
Living Well Central  
1555 Central Avenue Southwest  
Cambridge, MN 55008

RE: Event ID: 45JS12

Dear Administrator:

On November 24, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Compliance Analyst | Federal Enforcement  
Health Regulation Division  
Minnesota Department of Health  
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October 29, 2025

Administrator  
Living Well Central  
1555 Central Avenue Southwest  
Cambridge, MN 55008

RE: Event ID: 45JS11

Dear Administrator:

On October 10, 2025, a standard abbreviated survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. At the time of the survey, the survey team noted one or more deficiencies.

Federal certification deficiencies are delineated on the electronically delivered form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC). **A provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.**

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

**Failure to submit an acceptable written plan of correction for all Health Federal deficiencies within ten calendar days may result in additional remedies and/or decertification including a loss of federal reimbursement.**

Your PoC must include:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

Living Well Central

October 29, 2025

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make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

**DEPARTMENT CONTACT:**

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

Susie Haben, Regional Operations Supervisor, Rapid Response

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: [susie.haben@state.mn.us](mailto:susie.haben@state.mn.us)

Office: (320) 223-7356 Mobile: (651) 230-2334

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

Sincerely,



Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

**Minnesota Department of Health**

[Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)

Office: 651-201-4112

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

PRINTED: 10/29/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24G354</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/10/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIVING WELL CENTRAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1555 CENTRAL AVENUE SOUTHWEST CAMBRIDGE, MN 55008</b>
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>On 10/08/25 through 10/10/25, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.</p> <p>The Condition of Client Protections 42 CFR 483.420 was found not met at W122.</p> <p>The following complaint was reviewed HG3545523C (MN115264) with a deficiency issued at W149.</p> <p>Additionally, deficiencies were cited as a result of incidental findings not directly related to the complaint at W153 and W154.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	W 000		
W 122	<p><b>CLIENT PROTECTIONS</b> CFR(s): 483.420(a)</p> <p>The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on observation, interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed to protect 6 of 6 clients (C1, C2, C3, C4, C5, and C6 ) from neglect when incidents of staff neglect were not reported, investigated and clients were not protected timely. Additionally, clients were left unsupervised in the home for</p>	W 122		

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 122	Continued From page 1 approximately two hours.  Findings include:  See W149: The facility failed to implement abuse and neglect policies related to reporting, investigations, and client protections for 6 of 6 clients (C1, C2, C3, C4, C5 and C6) who were at risk for neglect when a staff had an allegation of neglect on 9/29/25, was allowed to continue to work, then on 10/3/25 left the clients alone in the home for approximately two hours.  See W153: The facility failed to report allegations of neglect to the state agency (SA ) for 3 of 3 clients (C2, C5 and C6) who did not receive incontinent cares and were found soaked with urine on 9/29/25, and 6 of 6 clients (C1, C2, C3 C4 C5 and C6 ) for an allegation of neglect to supervise, when clients were left alone in the home for approximately two hours.  See W154: The facility failed to thoroughly investigate and protect clients from potential future neglect for 3 of 3 clients (C2, C5 and C6) who who did not receive incontinent cares and were found soaked with urine. In addition, direct support professional (DSP)-A was allowed to continue to work without a thorough investigation of the alleged neglect, which led to further neglect.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1)  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by:	W 149		

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W 149	<p>Continued From page 2</p> <p>Based on interview and document review, the facility failed to implement abuse and neglect policies related to reporting, investigations, and client protections for 6 of 6 clients (C1, C2, C3, C4, C5 and C6) who were at risk for neglect when a staff had an allegation of neglect on 9/29/25, was allowed to continue to work, then on 10/3/25 left the clients alone in the home for approximately two hours.</p> <p>Findings include:</p> <p>C1's Emergency Data Form (EDF) dated 4/13/2020, indicated C1 had diagnosis of severe intellectual disability, neurogenic bladder and required a leg bag catheter. The EDF further indicated C1 walked on his own and had verbal communication.</p> <p>C1's Individual Abuse Prevention Plan (IAPP) dated 5/13/25, indicated C1 was at risk for physical abuse, required supervision at home and day program 24-hours a day unless with family. The IAPP further indicated he was unable to care for himself and counts on staff to report neglect.</p> <p>C2's EDF dated 10/09/25, indicated C2 had diagnosis of moderate intellectual disability, cerebral palsy (difficulties with making and/or controlling their body movements. This difficulty is the result of damage to the brain areas that control movements), seizure disorder, sleep disturbances and convulsions. C2's EDF further indicated he was verbal and required a wheelchair for mobility.</p> <p>C2's IAPP dated 5/13/25, indicated he required</p>	W 149		

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W 149	<p>Continued From page 3</p> <p>staff support 24 hours a day unless with family. C2's SMA dated 5/13/25, indicated his seizure disorder was controlled with medication, although had a history of tonic-clonic seizures (known as a grand mal seizure, causes loss of consciousness and violent muscle contractions). The Self-Management Assessment (SMA) also indicated staff were trained on C2's seizure protocol and approved alarm used when he was alone in his room to alert staff of a seizure.</p> <p>C3's EDF dated 04/13/2020, indicated C3 had diagnosis of type two diabetes mellitus, vision loss and sleep disturbance. C3's EDF further indicated he was verbal and used a walker for mobility.</p> <p>C3's IAPP dated 7/29/25, indicated he required 24-hour supervision. C3's SMA dated 7/29/25, indicated C3 had moderate intellectual disability which affected his ability to care for himself and make safe decisions for his care needs.</p> <p>C4's EDF dated 10/14/25, indicated C4 had a diagnosis of depression disorder, severe obstructive sleep apnea, hemi-plegia (paralysis on one side of the body) and congestive heart failure. C4's EDF further indicated he used a wheelchair and would verbally communicate.</p> <p>C4's IAPP dated 3/04/25, indicated he required 24-hour supervision. C4 SMA dated 2/26/25, indicated a diagnosis of a seizure disorder and staff were trained on his seizure protocol, how to recognize a seizure and C4's had bedroom sound alert system during the night. The SMA also indicated C4 had a diagnosis of cerebral palsy which affects the muscles of his body and</p>	W 149		

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W 149	<p>Continued From page 4</p> <p>required the use of a wheelchair. In addition, C4 had a neurogenic bladder which puts him at risk of incontinence, though most the time he was continent. The SMA further indicated he had a CPAP machine that staff are to check on four times during the evening/overnight to make visual check for mask in place and tubing as clear.</p> <p>C5's EDF dated 02/06/2025, indicated C5 had diagnosis of Schizoaffective disorder, mild intellectual disability, neuromuscular dysfunction of bladder (when nerve damage affects bladder control, leading to symptoms like incontinence or urinary retention).</p> <p>C5's IAPP dated 2/06/25, indicated C5 required 24-hour supervision. C5's SMA dated 2/06/25, indicated C5 was at risk for falls. The SMA indicated C5 was at risk of incontinence at night, may require verbal cue to use brief.</p> <p>C6's EDF dated 10/09/25, indicated she had diagnosis of profound intellectual disability, infantile cerebral palsy, bipolar disorder and constipation.</p> <p>C6's IAPP dated 3/12/25, indicated she required 24-hour staff supervision. C6 SMA dated 3/12/25, indicated her gait and balance was unsteady and could result in injury from falls or bumping into things and difficulty walking on uneven ground. Observation on 10/8/25, at 2:15 p.m. C6 was observed wearing a soft helmet walking around the home, continued to grab staffs' hand, leading staff to different locations.</p> <p>A Facility Reported Incident indicated on</p>	W 149		

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W 149	<p>Continued From page 5</p> <p>10/03/25 at 11:23 p.m., the homes exterior cameras showed direct support professional (DSP)-A walk out of the front door of the house and got into a car, left the driveway at 11:26 p.m. and returned at 1:12 a.m. on 10/04/25. The report indicated door was left unlocked and the six vulnerable adults that lived at the home were left alone for approximately two hours. The incident was reported to the State Agency (SA) on 10/04/25 at 10:35 a.m. (over nine hours after the incident occurred).</p> <p>During interview on 10/08/25 at 2:10 p.m., program manager (PM) stated she was planning to talk with DSP-A on 10/03/25, related to complaints from day shift that clients were left soaked with urine in the morning. The PM said she was informed by dayshift staff how C2, C5 and C6 were found on 9/29/25, incontinent of urine, required bed changes and baths. In addition, the PM stated DSP-A was behind on her training and was not documenting in the home's computer program called Therap. The PM stated she had been texting and calling DSP-A with no response and felt it was best to show up at the home when she worked next. When asked why she allowed DSP-A to work another shift pending her investigation, PM indicated she wanted to give DSP-A a chance to hear her side of the story first. Then, on the night of 10/03/25 to 10/04/25, PM indicated she received an alert on her cell phone at 1:12 a.m. which showed DSP-A walking into the home and when she reviewed the camera footage further, she discovered DSP-A had left the house at 11:26 p.m. The PM stated she went to the home and arrived at 3:00 a.m. to first check on the clients and then spoke to DSP-A, who stated she</p>	W 149		

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W 149	<p>Continued From page 6</p> <p>had an argument with her boyfriend and never left the driveway. The PM stated she believed this was not true as the camera footage showed her leaving in a car at 11:26 p.m. and then returning at 1:12 a.m. The PM stated she discussed her concerns with the incident on 9/29/25 and with DSP-A leaving the clients alone in the home and suspended her pending investigation.</p> <p>On 10/10/25 at 10:00 a.m. upon request, PM was unable to provide cell phone text message or call log record indicating DSP-A had been attempted to be contacted between 9/29/25 and 10/4/25.</p> <p>During interview on 10/08/25 at 7:05 p.m., DSP-A stated she responded to a text from her PM on 9/26/25 related to getting access to the company's electronic documentation system (Therap), stating she could come in anytime that week but never received a response back from her. DSP-A state PM arrived at the house on 10/04/25, at 3:00 a.m. informing her cares were not being completed on the clients and then dismissed her from the shift due to leaving the clients alone during the night. DSP-A then stated she gets anxious during the night and on 10/03/25, her boyfriend came to talk since they had been going through some stuff; so, we talked and lost track of time. DSP-A stated on 10/03/25 he came to the house, and smoked weed (marijuana) from a vape pen but did not bring it into the home.</p> <p>During interview on 10/09/25 at 11:34 a.m., assistant program manager (APM)-A stated she arrived to work on 9/29/25 at 6:00 a.m., and DSP-A was sitting on the couch relaxing and said all the clients were fine. APM-A stated when she</p>	W 149		

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W 149	<p>Continued From page 7</p> <p>walked into the door the smell of urine was "so strong", you could smell urine all through the hallways upstairs and where C5's room was. C2's clothes and bed were soaking wet with urine which was unusual for him as he would call for help to use the toilet at night and would remain continent. In addition, APM stated C6 was soaking wet with urine, and they had to bring her to the toilet and all three of the clients required baths as well as all bedding needed to be completed changed and disinfected. APM-A stated she had never seen those clients so wet in the seven years she had worked at the home, and it seemed like DSP-A had not done anything the entire nightshift. APM-A indicated she and DSP-B both reported the allegation to the PM right away that morning and was directed to send an email to her. APM-A stated she was not aware of any concerns of DSP-A using drugs or alcohol while she was working.</p> <p>During interview on 10/09/25 at 11:56 a.m., DSP-B stated she arrived to work on 9/29/25 around 5:50 a.m., knocked on the door three times and rang the doorbell until finally DSP-A came to the door with a blanket wrapped around her. DSP-B stated she said the night went fine. DSP-B stated C2 was sitting on the edge of his bed, naked from the waist down and soaked with urine. Staff had to remove everything off his bed, including the mattress pad covering and disinfect the entire mattress. DSP-B stated based on how she found C2, she would assume C2 waited a long time to be assisted. DSP-B then stated she was shocked and had never seen anything like this before. In addition, DSP-B stated C5 was also completely soaked with urine including his bedding and even his pillow.</p>	W 149		

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W 149	<p>Continued From page 8</p> <p>During a second interview on 10/09/25 at 2:27 p.m., PM approached surveyor and indicated she was not sure now how she contacted DSP-A but stated she called DSP-A using the home phone instead, again explaining she was planning on meeting with her during her shift on 10/3/25-10/4/25 but had fallen asleep. PM stated she did not report the alleged neglect to the SA since she was unable to contact DSP-A and felt she needed to complete an investigation first before reporting to the SA. The PM stated she informed the guardians of the incident that occurred on 10/04/25. PM-A stated she was shocked to find out DSP-A reported she had been using marijuana while working and was never informed of any concerns.</p> <p>During interview on 10/09/25 at 6:20 p.m., C5's guardians stated they were unaware of either incident and never received a phone call regarding them.</p> <p>During interview on 10/09/25 at 4:50 p.m., regional director (RD) stated she was aware of the incident related to lack of cares being provided by DSP-A during the night shift on 9/29/25, but was unaware of how serious it was, "I should have asked more questions when it was first brought to my attention." The RD stated she had a conversation with the PM, and it was decided then not to report the incident since there was no harm that occurred at the time. RD stated she did instruct her to investigate the incident, but it appears the PM may not have. In addition, the RD stated the incident that occurred on 10/03/25 to 10/04/25 with DSP-A of neglect to supervise, should have been reported</p>	W 149		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24G354</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/10/2025</b>
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W 149	Continued From page 9 immediately according to policy and they have a no smoking policy at the home.	W 149		
W 153	<p><b>STAFF TREATMENT OF CLIENTS</b> CFR(s): 483.420(d)(2)</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to report allegations of neglect to the state agency (SA ) for 3 of 3 clients (C2, C5 and C6) who did not receive incontinent cares and were found soaked with urine on 9/29/25, and 6 of 6 clients (C1, C2, C3 C4 C5 and C6 ) for an allegation of neglect to supervise, when clients were left alone in the home for approximately two hours.</p> <p>Findings include:</p> <p>C1's Emergency Data Form (EDF) dated 4/13/2020, indicated C1 had a diagnosis of</p>	W 153		

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W 153	<p>Continued From page 10</p> <p>severe intellectual disability.</p> <p>C2's EDF dated 10/09/25, indicated C2 had diagnosis of moderate intellectual disability and a seizure disorder.</p> <p>C3's EDF dated 04/13/2020, indicated C4 had diagnosis of moderate intellectual disability.</p> <p>C4's EDF dated 10/14/25, indicated C4 had diagnosis of mild intellectual disability and a seizure disorder.</p> <p>C5's EDF dated 02/06/2025, indicated C5 had diagnosis of mild intellectual disability, neuromuscular dysfunction of bladder (when nerve damage affects bladder control, leading to symptoms like incontinence or urinary retention).</p> <p>C6's EDF dated 10/09/25, indicated C5 had diagnosis of profound intellectual disability, infantile cerebral palsy, bipolar disorder and constipation.</p> <p>During interview on 10/09/25 at 11:34 a.m., assistant program manager (APM)-A stated she arrived to work on 9/29/25 at 6:00 a.m., and DSP-A was sitting on the couch relaxing and said all the clients were fine. APM-A stated when she walked into the door the smell of urine was "so strong", you could smell urine all through the hallways upstairs and where C5's room was. C2's clothes and bed were soaking wet with urine which was unusual for him as he would call for help to use the toilet at night and would remain continent. In addition, APM stated C6 was soaking wet with urine, and they had to bring her to the toilet and all three of the clients required baths as well as all bedding needed to be</p>	W 153		

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W 153	<p>Continued From page 11</p> <p>completed changed and disinfected. APM-A stated she had never seen those clients so wet in the seven years she had worked at the home, and it seemed like DSP-A had not done anything the entire nightshift. APM-A indicated she and DSP-B both reported the allegation to the PM right away that morning and was directed to send an email to her. APM-A stated she was not aware of any concerns of DSP-A using drugs or alcohol while she was working.</p> <p>During interview on 10/09/25 at 11:56 a.m., DSP-B stated she arrived to work on 9/29/25 around 5:50 a.m., knocked on the door three times and rang the doorbell until finally DSP-A came to the door with a blanket wrapped around her. DSP-B stated she said the night went fine. DSP-B stated C2 was sitting on the edge of his bed, naked from the waist down and soaked with urine. Staff had to remove everything off his bed, including the mattress pad covering and disinfect the entire mattress. DSP-B stated based on how she found C2, she would assume C2 waited a long time to be assisted. DSP-B then stated she was shocked and had never seen anything like this before. In addition, DSP-B stated C5 was also completely soaked with urine including his bedding and even his pillow.</p> <p>A Facility Reported Incident indicated on 10/03/25 at 11:23 p.m., the homes exterior cameras showed direct support professional (DSP)-A walk out of the front door of the house and got into a car, left the driveway at 11:26 p.m. and returned at 1:12 a.m. on 10/04/25. The reported indicated door was left unlocked and the six vulnerable adults that lived at the home were left alone for approximately two hours. The</p>	W 153		

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W 153	<p>Continued From page 12</p> <p>incident was reported to the State Agency (SA) on 10/04/25 at 10:35 a.m. (over nine hours after the incident occurred)</p> <p>During interview on 10/08/25 at 2:10 p.m., program manager (PM) stated she was informed by dayshift staff how C2, C5 and C6 were found on 9/29/25, incontinent of urine, required bed changes and baths. She indicated she reported the concern to her Regional Director (RD)-A the same day, but they did not determine it was reportable. Then, on the night of 10/03/25 to 10/04/25, PM indicated she received an alert on her cell phone at 1:12 a.m. which showed DSP-A walking into the home and when she reviewed the camera footage further, she discovered DSP-A had left the house at 11:26 p.m. The PM stated she went to the home and arrived at 3:00 a.m. to first check on the clients and then spoke to DSP-A, who stated she had an argument with her boyfriend and never left the driveway. The PM stated she believed this was not true as the camera footage showed her leaving in a car at 11:26 p.m. and then returning at 1:12 a.m. The PM stated she discussed her concerns with the incident on 9/29/25 and with DSP-A leaving the clients alone in the home and suspended her pending investigation. PM-A indicated she waited to report the incident until the following morning of 10/4/25. She stated she believed that was timely reporting.</p> <p>During interview on 10/09/25 at 4:50 p.m., regional director (RD) stated she was aware of the incident related to lack of cares being provided by DSP-A during the night shift on 9/29/25, but was unaware of how serious it was, "I should have asked more questions when it was</p>	W 153		

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W 153	Continued From page 13 first brought to my attention." The RD stated she had a conversation with the PM, and it was decided then not to report the incident since there was no harm that occurred at the time. RD stated she did instruct her to investigate the incident, but it appears the PM may not have. In addition, the RD stated the incident that occurred on 10/03/25 to 10/04/25 with DSP-A of neglect to supervise, should have been reported immediately according to policy.  Vulnerable Adults Maltreatment Reporting and Internal Review Policy revised 2/18/25, indicated it is the policy of Living Well Disability Services to protect the adults served by this program who are vulnerable to maltreatment and to require the reporting of suspected maltreatment of vulnerable adults and upon knowledge of an incident of maltreatment, a report must be made to the Minnesota Adult Abuse Reporting Center (MAARC) immediately.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)  The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview, observation and record review the facility failed to thoroughly investigate and protect clients from potential future neglect for 3 of 3 clients (C2, C5 and C6) who who did not receive incontinent cares and were found soaked with urine. In addition, direct support professional (DSP)-A was allowed to continue to work without a thorough investigation of the alleged neglect, which led to further neglect.  Findings include:	W 154		

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W 154	<p>Continued From page 14</p> <p>C2's EDF dated 10/09/25, indicated C2 had diagnosis of moderate intellectual disability and a seizure disorder.</p> <p>C5's EDF dated 02/06/2025, indicated C5 had diagnosis of mild intellectual disability, neuromuscular dysfunction of bladder (when nerve damage affects bladder control, leading to symptoms like incontinence or urinary retention).</p> <p>C6's EDF dated 10/09/25, indicated C5 had diagnosis of profound intellectual disability, infantile cerebral palsy, and bipolar disorder.</p> <p>During interview on 10/09/25 at 11:34 a.m., assistant program manager (APM)-A stated she arrived to work on 9/29/25 at 6:00 a.m., and DSP-A was sitting on the couch relaxing and said all the clients were fine. APM-A stated when she walked into the door the smell of urine was "so strong", you could smell urine all through the hallways upstairs and where C5's room was. C2's clothes and bed were soaking wet with urine which was unusual for him as he would call for help to use the toilet at night and would remain continent. In addition, APM stated C6 was soaking wet with urine, and they had to bring her to the toilet and all three of the clients required baths as well as all bedding needed to be completed changed and disinfected. APM-A stated she had never seen those clients so wet in the seven years she had worked at the home, and it seemed like DSP-A had not done anything the entire nightshift. APM-A indicated she and DSP-B both reported the allegation to the PM right away that morning and was directed to send an email to her. APM-A stated she was not</p>	W 154		

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W 154	<p>Continued From page 15</p> <p>aware of any concerns of DSP-A using drugs or alcohol while she was working.</p> <p>During interview on 10/09/25 at 11:56 a.m., DSP-B stated she arrived to work on 9/29/25 around 5:50 a.m., knocked on the door three times and rang the doorbell until finally DSP-A came to the door with a blanket wrapped around her. DSP-B stated she said the night went fine. DSP-B stated C2 was sitting on the edge of his bed, naked from the waist down and soaked with urine. Staff had to remove everything off his bed, including the mattress pad covering and disinfect the entire mattress. DSP-B stated based on how she found C2, she would assume C2 waited a long time to be assisted. DSP-B then stated she was shocked and had never seen anything like this before. In addition, DSP-B stated C5 was also completely soaked with urine including his bedding and even his pillow.</p> <p>During interview on 10/08/25 at 2:10 p.m., program manager (PM) stated she was planning to talk with DSP-A on 10/03/25, related to complaints from day shift that clients were left soaked with urine in the morning. The PM said she was informed by dayshift staff how C2, C5 and C6 were found on 9/29/25, incontinent of urine, required bed changes and baths. In addition, the PM stated she had been texting and calling DSP-A with no response and felt it was best to show up at the home when she worked next (10/3/25). When asked why she allowed DSP-A to work another shift pending her investigation, PM indicated she wanted to give DSP-A a chance to hear her side of the story first. Then, on the night of 10/03/25 to 10/04/25, PM indicated she received an alert on her cell</p>	W 154		

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W 154	<p>Continued From page 16</p> <p>phone at 1:12 a.m. which showed DSP-A walking into the home and when she reviewed the camera footage further, she discovered DSP-A had left the house at 11:26 p.m. The PM stated she went to the home and arrived at 3:00 a.m. to first check on the clients and then spoke to DSP-A, who stated she had an argument with her boyfriend and never left the driveway. The PM stated she believed this was not true as the camera footage showed her leaving in a car at 11:26 p.m. and then returning at 1:12 a.m. The PM stated she discussed her concerns with the incident on 9/29/25 and with DSP-A leaving the clients alone in the home and suspended her pending investigation.</p> <p>During a second interview on 10/09/25 at 2:27 p.m., PM approached surveyor and indicated she was not sure now how she contacted DSP-A but stated she called DSP-A using the home phone instead, again explaining she was planning on meeting with her during her shift on 10/3/25-10/4/25 but had fallen asleep. PM stated she did not report the alleged neglect to the SA since she was unable to contact DSP-A and felt she needed to complete an investigation first before reporting to the SA. PM-A stated she was shocked to find out DSP-A reported she had been using marijuana while working and was never informed of any concerns.</p> <p>On 10/10/25 at 10:00 a.m. upon request, PM was unable to provide cell phone text message or call log record indicating DSP-A had been attempted to be contacted between 9/29/25 and 10/4/25.</p> <p>During interview on 10/09/25 at 4:50 p.m., regional director (RD) stated she was aware of</p>	W 154		

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W 154	<p>Continued From page 17</p> <p>the incident related to lack of cares being provided by DSP-A during the night shift on 9/29/25, but was unaware of how serious it was, "I should have asked more questions when it was first brought to my attention." The RD stated she had a conversation with the PM, and it was decided then not to report the incident since there was no harm that occurred at the time. RD stated she did instruct her to investigate the incident, but it appears she may not have.</p> <p>Vulnerable Adults Maltreatment Reporting and Internal Review policy revised 2/18/2025, indicated:</p> <ol style="list-style-type: none"> <li>1. When Living Well Disability Services has reason to know that an internal or external report of alleged or suspected maltreatment has been made, the organization must complete an internal review and take corrective action, if necessary, to protect the health and safety of vulnerable adults.</li> <li>2. The internal review must include an evaluation of whether: <ol style="list-style-type: none"> <li>a. related policies and procedures were followed.</li> <li>b. the policies and procedures were adequate.</li> <li>c. there is a need for additional staff training.</li> <li>d. the reported event is similar to past events with the vulnerable adults or the services involved.</li> <li>e. there is a need for corrective action by the organization to protect the health and safety of vulnerable adults.</li> </ol> </li> <li>3. The internal review must be completed within 5 working days.</li> </ol>	W 154		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

October 29, 2025

Administrator  
Living Well Central  
1555 Central Avenue Southwest  
Cambridge, MN 55008

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: 45JS11

Dear Administrator:

The above facility was surveyed on October 8, 2025 through October 10, 2025 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

**The first page of the state orders should be signed and submitted along with your federal plan of correction to:**

Living Well Central

October 29, 2025

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Susie Haben, Regional Operations Supervisor, Rapid Response  
Health Regulation Division  
Minnesota Department of Health  
4140 Thielman Lane  
Saint Cloud, Minnesota 56301-4557  
Email: susie.haben@state.mn.us  
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

Sincerely,



Kamala Fiske-Downing  
Compliance Analyst | Federal Enforcement  
Health Regulation Division  
**Minnesota Department of Health**  
[Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)  
Office: 651-201-4112

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01371</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/10/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIVING WELL CENTRAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1555 CENTRAL AVENUE SOUTHWEST CAMBRIDGE, MN 55008</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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5 000	<p><b>Initial Comments</b></p> <p>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.</p> <p>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.</p> <p>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 10/08/25 through 10/10/25, a standard abbreviated survey was conducted. Your facility was found to be not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).</p> <p>The following complaint was reviewed. HG3545523C (MN115264) with licensing orders issued at 0815.</p>	5 000		
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Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

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5 000	Continued From page 1  When corrections are completed, please sign and date, make a copy of these orders and electronically return to:  Susie.Haben@state.mn.us	5 000		
5 815	MN Statute 626.557 Subd. 3. VA Timing of report.  (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has	5 815		

Minnesota Department of Health

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5 815	<p>Continued From page 2</p> <p>reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to report allegations of neglect to the state agency (SA ) for 3 of 3 clients (C2, C5 and C6) who did not receive incontinent cares and were found soaked with urine on 9/29/25, and 6 of 6 clients (C1, C2, C3 C4 C5 and C6 ) for an allegation of neglect to supervise, when clients were left alone in the home for approximately two hours. Findings include: C1's Emergency Data Form (EDF) dated 4/13/2020, indicated C1 had a diagnosis of severe intellectual disability. C2's EDF dated 10/09/25, indicated C2 had diagnosis of moderate intellectual disability and a seizure disorder.  C3's EDF dated 04/13/2020, indicated C4 had diagnosis of moderate intellectual disability.</p>	5 815		
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5 815	<p>Continued From page 3</p> <p>C4's EDF dated 10/14/25, indicated C4 had diagnosis of mild intellectual disability and a seizure disorder.</p> <p>C5's EDF dated 02/06/2025, indicated C5 had diagnosis of mild intellectual disability, neuromuscular dysfunction of bladder (when nerve damage affects bladder control, leading to symptoms like incontinence or urinary retention).</p> <p>C6's EDF dated 10/09/25, indicated C5 had diagnosis of profound intellectual disability, infantile cerebral palsy, bipolar disorder and constipation.</p> <p>During interview on 10/09/25 at 11:34 a.m., assistant program manager (APM)-A stated she arrived to work on 9/29/25 at 6:00 a.m., and DSP-A was sitting on the couch relaxing and said all the clients were fine. APM-A stated when she walked into the door the smell of urine was "so strong", you could smell urine all through the hallways upstairs and where C5's room was. C2's clothes and bed were soaking wet with urine which was unusual for him as he would call for help to use the toilet at night and would remain continent. In addition, APM stated C6 was soaking wet with urine, and they had to bring her to the toilet and all three of the clients required baths as well as all bedding needed to be completed changed and disinfected. APM-A stated she had never seen those clients so wet in the seven years she had worked at the home, and it seemed like DSP-A had not done anything the entire nightshift. APM-A indicated she and DSP-B both reported the allegation to the PM right away that morning and was directed to send an email to her. APM-A stated she was not aware of any concerns of DSP-A using drugs or</p>	5 815		
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5 815	<p>Continued From page 4</p> <p>alcohol while she was working.</p> <p>During interview on 10/09/25 at 11:56 a.m., DSP-B stated she arrived to work on 9/29/25 around 5:50 a.m., knocked on the door three times and rang the doorbell until finally DSP-A came to the door with a blanket wrapped around her. DSP-B stated she said the night went fine. DSP-B stated C2 was sitting on the edge of his bed, naked from the waist down and soaked with urine. Staff had to remove everything off his bed, including the mattress pad covering and disinfect the entire mattress. DSP-B stated based on how she found C2, she would assume C2 waited a long time to be assisted. DSP-B then stated she was shocked and had never seen anything like this before. In addition, DSP-B stated C5 was also completely soaked with urine including his bedding and even his pillow.</p> <p>A Facility Reported Incident indicated on 10/03/25 at 11:23 p.m., the homes exterior cameras showed direct support professional (DSP)-A walk out of the front door of the house and got into a car, left the driveway at 11:26 p.m. and returned at 1:12 a.m. on 10/04/25. The reported indicated door was left unlocked and the six vulnerable adults that lived at the home were left alone for approximately two hours. The incident was reported to the State Agency (SA) on 10/04/25 at 10:35 a.m. (over nine hours after the incident occurred)</p> <p>During interview on 10/08/25 at 2:10 p.m., program manager (PM) stated she was informed by dayshift staff how C2, C5 and C6 were found on 9/29/25, incontinent of urine, required bed changes and baths. She indicated she reported the concern to her Regional Director (RD)-A the</p>	5 815		
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5 815	<p>Continued From page 5</p> <p>same day, but they did not determine it was reportable. Then, on the night of 10/03/25 to 10/04/25, PM indicated she received an alert on her cell phone at 1:12 a.m. which showed DSP-A walking into the home and when she reviewed the camera footage further, she discovered DSP-A had left the house at 11:26 p.m. The PM stated she went to the home and arrived at 3:00 a.m. to first check on the clients and then spoke to DSP-A, who stated she had an argument with her boyfriend and never left the driveway. The PM stated she believed this was not true as the camera footage showed her leaving in a car at 11:26 p.m. and then returning at 1:12 a.m. The PM stated she discussed her concerns with the incident on 9/29/25 and with DSP-A leaving the clients alone in the home and suspended her pending investigation. PM-A indicated she waited to report the incident until the following morning of 10/4/25. She stated she believed that was timely reporting.</p> <p>During interview on 10/09/25 at 4:50 p.m., regional director (RD) stated she was aware of the incident related to lack of cares being provided by DSP-A during the night shift on 9/29/25, but was unaware of how serious it was, "I should have asked more questions when it was first brought to my attention." The RD stated she had a conversation with the PM, and it was decided then not to report the incident since there was no harm that occurred at the time. RD stated she did instruct her to investigate the incident, but it appears the PM may not have. In addition, the RD stated the incident that occurred on 10/03/25 to 10/04/25 with DSP-A of neglect to supervise, should have been reported immediately according to policy.</p>	5 815		
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5 815	<p>Continued From page 6</p> <p>Vulnerable Adults Maltreatment Reporting and Internal Review Policy revised 2/18/25, indicated it is the policy of Living Well Disability Services to protect the adults served by this program who are vulnerable to maltreatment and to require the reporting of suspected maltreatment of vulnerable adults and upon knowledge of an incident of maltreatment, a report must be made to the Minnesota Adult Abuse Reporting Center (MAARC) immediately.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	5 815		
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*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered Via Email

October 29, 2025

Administrator  
Living Well Central  
1555 Central Avenue Southwest  
Cambridge, MN 55008

RE: Event ID: 45JS11

Dear Administrator:

On October 10, 2025, a standard abbreviated survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. At the time of the survey, the survey team noted one or more deficiencies.

Federal certification deficiencies are delineated on the electronically delivered form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC). **A provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.**

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

**Failure to submit an acceptable written plan of correction for all Health Federal deficiencies within ten calendar days may result in additional remedies and/or decertification including a loss of federal reimbursement.**

Your PoC must include:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

Living Well Central

October 29, 2025

Page 2

make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

**DEPARTMENT CONTACT:**

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

Susie Haben, Regional Operations Supervisor, Rapid Response

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: [susie.haben@state.mn.us](mailto:susie.haben@state.mn.us)

Office: (320) 223-7356 Mobile: (651) 230-2334

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

Sincerely,



Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

**Minnesota Department of Health**

[Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)

Office: 651-201-4112

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

PRINTED: 10/29/2025  
FORM APPROVED  
OMB NO. 0938-0391

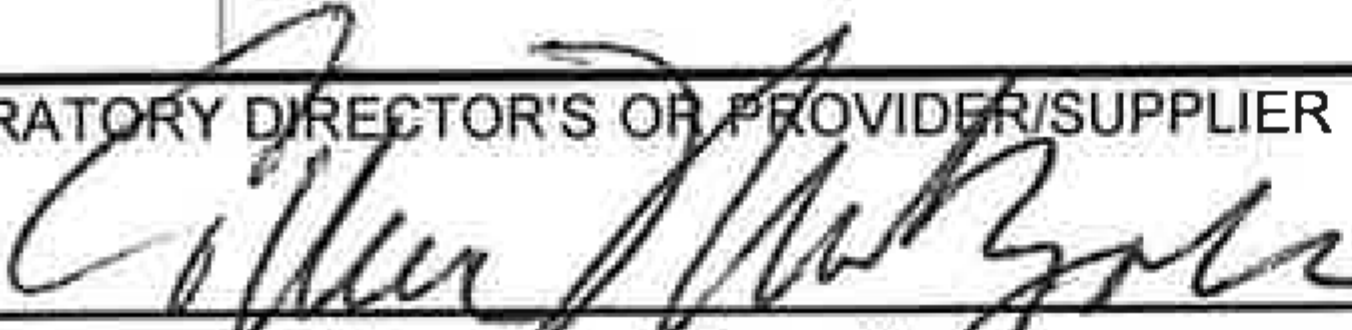
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24G354</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/10/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIVING WELL CENTRAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1555 CENTRAL AVENUE SOUTHWEST CAMBRIDGE, MN 55008</b>		
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W 000	INITIAL COMMENTS  On 10/08/25 through 10/10/25, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.  The Condition of Client Protections 42 CFR 483.420 was found not met at W122.  The following complaint was reviewed HG3545523C (MN115264) with a deficiency issued at W149.  Additionally, deficiencies were cited as a result of incidental findings not directly related to the complaint at W153 and W154.  Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	W 000	received 11/14/25 reviewed 11/19/25 POC 11/19/25  <i>Susie Haben</i>	By 11/19/25 and ongoing	
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a)  The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on observation, interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed to protect 6 of 6 clients (C1, C2, C3, C4, C5, and C6 ) from neglect when incidents of staff neglect were not reported, investigated and clients were not protected timely. Additionally, clients were left unsupervised in the home for	W 122	<b>W122 Client Protections</b> <b>CFR(s): 483.420(a)</b> <b>a-</b> Immediately and going forward the Program Manager for Living Well Central will ensure to protect all clients (C1, C2, C3, C4, C5, C6) from neglect by immediately reporting and investigating all incidents of neglect and/or abuse witnessed by Program Manager or when brought to the attention of the Program Manager by either an employee, outside agency or team member and as it applies for C1, C2, C3, C4, C5, C6. <b>b-</b> The Regional Director, as the supervisor for the Program Manager at Central, will provide retraining for the Program Manager to include but not be limited review of the organizational <i>Vulnerable Adults Maltreatment Reporting and Internal Review Policy</i> which defines immediate reporting to MAARC, and administrator whenever an employee is involved in alleged incident or suspected of maltreatment. Additionally, the		

Regional Director will review the organizational Employee Handbook section entitled *Standards of Conduct and Practice*, specifically with regards to employee performance and providing care to ensure the health and safety of all clients and specifically pertaining to incident involving egregious lack of care for C2, C5, C6 who experienced several episodes of incontinence during a shift and who were not assisted and changed in a timely manner. Regional Director will also review the expectation that the Program Manager immediately address when an employee fails to obtain permission to leave a shift or the premises during scheduled work time. Training will emphasize that going forward the Program Manager will immediately address any conduct or performance concerns of any employee as soon as the Program Manager has knowledge of concerns with a specific employee. The retraining for the Program Manager will occur by 11/7/25. (The specific employee involved in this allegation was terminated from employment on 10/10/25).

11/19/25  
and  
ongoing  
↓

- c- To protect the rights of all clients immediately and going forward the Program Manager will make periodic checks of all shifts and all employees, specifically the overnight shift of employees, to ensure the employees are documenting and completing assigned cares and tasks on their specific shift. Any time it is determined by the Program Manager or reported to the Program Manager by an employee that conduct or performance of a specific employee places any client at risk for maltreatment, neglect of abuse, the Program Manager will immediately address the conduct and performance of any employee and determine appropriate coaching or disciplinary action to be taken up to and including termination. The Program Manager will report any incident leading to disciplinary concerns to the Regional Director

		<p>and Human Resources department for Living Well.</p> <p>d- The Program Manager will provide a retraining to all employees to include but not be limited to the <i>Vulnerable Adult and Maltreatment Reporting and Internal Review Policy</i> and as it applies to the specific incident of neglect that occurred and review the expectation to immediately notify the Program Manager of any actual or suspected maltreatment and neglect of any client, and specifically C2, 25, and C6 and to immediately report any incidents of suspected misconduct of any employee. Training will occur by 11/19/25.</p> <p>d- The Program Manager will monitor compliance by using the organizational Quality Assurance tool known as Compass, specifically to a Quality Improvement Work Plan.</p> <p>e- The Regional Director is responsible for overall compliance with this citation.</p>	<p>11/19/25 and ongoing</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Program Support Director	11/13/25

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 122	Continued From page 1 approximately two hours.  Findings include:  See W149: The facility failed to implement abuse and neglect policies related to reporting, investigations, and client protections for 6 of 6 clients (C1, C2, C3, C4, C5 and C6) who were at risk for neglect when a staff had an allegation of neglect on 9/29/25, was allowed to continue to work, then on 10/3/25 left the clients alone in the home for approximately two hours.  See W153: The facility failed to report allegations of neglect to the state agency (SA ) for 3 of 3 clients (C2, C5 and C6) who did not receive incontinent cares and were found soaked with urine on 9/29/25, and 6 of 6 clients (C1, C2, C3 C4 C5 and C6 ) for an allegation of neglect to supervise, when clients were left alone in the home for approximately two hours.  See W154: The facility failed to thoroughly investigate and protect clients from potential future neglect for 3 of 3 clients (C2, C5 and C6) who who did not receive incontinent cares and were found soaked with urine. In addition, direct support professional (DSP)-A was allowed to continue to work without a thorough investigation of the alleged neglect, which led to further neglect.	W 122		By 11/19/25 and ongoing	
W 149	<b>STAFF TREATMENT OF CLIENTS</b> CFR(s): 483.420(d)(1)  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by:	W 149	<b>W149 Staff Treatment of Clients</b> <b>CFR(s): 483.429(d)(1)</b> <b>a-</b> Immediately and going forward, the Program Manager will adhere to all organizational policies and procedures prohibiting mistreatment, neglect or abuse of any client including C1, C2, C3, C4, C5, and C6 and specifically adhere to organizational policies for immediate reporting and investigation of all allegations of mistreatment, neglect or abuse. <b>b-</b> The Regional Director, as the supervisor for the Program Manager at Central, will provide retraining for the Program Manager to include but not be limited to review of the organizational <i>Vulnerable Adults Maltreatment Reporting and Internal Review Policy</i> as well as the organizational <i>Incident Reporting and Review Policy</i> that outlines and defines the requirement for immediate reporting to appropriate agencies such as MAARC and internal parties such as administrator once a Program Manager has knowledge that an incident occurred. Going forward the Program Manager will		

adhere to organizational policies and will immediately report to MAARC any incident of neglect, maltreatment and abuse involving any client and specifically C2, C5, and C6. Additionally, the Regional Director will provide the Program Manager with retraining regarding the requirement to immediately initiate an internal investigation when a report of maltreatment, neglect or abuse is made to MAARC Retraining will occur by 11/7/25.

11/19/25  
and  
ongoing



- c- The Regional Director will retrain the Program Manager to the *Incident Reporting and Review Policy* and *Employee Handbook* specific to disciplinary actions to be implemented by the Program Manager if an employee is suspected of maltreatment, neglect or abuse on any shift.
- d- The Program Manager will provide retraining for all employees. Training to include but not be limited to the requirement to immediately report any maltreatment, neglect or abuse of any client (C1, C2, C3, C4, C5, C6), to the Program Manager. Training will include the requirement for all employees to report the actions and behavior of any employee who is engaged in or is suspected of being engaged in behavior considered maltreatment, neglect, or abuse specifically as it pertains to lack of care for any client and particularly C2, C5 and C6 who were left incontinent and were not provided assistance to change into clean clothing and any time an employee leaves the premises without advance approval from the Program Manager which placed clients C1, C2, C3, C4, C5, and C6 at great risk. When an

incident of maltreatment, neglect

		<p>and abuse occurs, all employees not involved in the incident will provide care and supervision to ensure the wellbeing of all clients in the home when an incident occurs. Training will be completed by 11/19/25</p> <p>f- The Program Manager will monitor documentation progress and compliance by using the organizational Quality Assurance tool known as Compass, specifically to a Quality Improvement Work Plan.</p> <p>g- The Regional Director is responsible for overall compliance with this citation.</p>	<p><i>11/19/25 and ongoing</i></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24G354</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 10/10/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIVING WELL CENTRAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1555 CENTRAL AVENUE SOUTHWEST CAMBRIDGE, MN 55008</b>	
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			(X5) COMPLETION DATE

<p>W 149 Continued From page 2</p> <p>Based on interview and document review, the facility failed to implement abuse and neglect policies related to reporting, investigations, and client protections for 6 of 6 clients (C1, C2, C3, C4, C5 and C6) who were at risk for neglect when a staff had an allegation of neglect on 9/29/25, was allowed to continue to work, then on 10/3/25 left the clients alone in the home for approximately two hours.</p> <p>Findings include:</p> <p>C1's Emergency Data Form (EDF) dated 4/13/2020, indicated C1 had diagnosis of severe intellectual disability, neurogenic bladder and required a leg bag catheter. The EDF further indicated C1 walked on his own and had verbal communication.</p> <p>C1's Individual Abuse Prevention Plan (IAPP) dated 5/13/25, indicated C1 was at risk for physical abuse, required supervision at home and day program 24-hours a day unless with family. The IAPP further indicated he was unable to care for himself and counts on staff to report neglect.</p> <p>C2's EDF dated 10/09/25, indicated C2 had diagnosis of moderate intellectual disability, cerebral palsy (difficulties with making and/or controlling their body movements. This difficulty is the result of damage to the brain areas that control movements), seizure disorder, sleep disturbances and convulsions. C2's EDF further indicated he was verbal and required a wheelchair for mobility.</p> <p>C2's IAPP dated 5/13/25, indicated he required</p>	<p>W 149</p> <p>By 11/19/25 and ongoing</p>
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W 149	<p>Continued From page 3</p> <p>staff support 24 hours a day unless with family. C2's SMA dated 5/13/25, indicated his seizure disorder was controlled with medication, although had a history of tonic-clonic seizures (known as a grand mal seizure, causes loss of consciousness and violent muscle contractions). The Self-Management Assessment (SMA) also indicated staff were trained on C2's seizure protocol and approved alarm used when he was alone in his room to alert staff of a seizure.</p> <p>C3's EDF dated 04/13/2020, indicated C3 had diagnosis of type two diabetes mellitus, vision loss and sleep disturbance. C3's EDF further indicated he was verbal and used a walker for mobility.</p> <p>C3's IAPP dated 7/29/25, indicated he required 24-hour supervision. C3's SMA dated 7/29/25, indicated C3 had moderate intellectual disability which affected his ability to care for himself and make safe decisions for his care needs.</p> <p>C4's EDF dated 10/14/25, indicated C4 had a diagnosis of depression disorder, severe obstructive sleep apnea, hemi-plegia (paralysis on one side of the body) and congestive heart failure. C4's EDF further indicated he used a wheelchair and would verbally communicate.</p> <p>C4's IAPP dated 3/04/25, indicated he required 24-hour supervision. C4 SMA dated 2/26/25, indicated a diagnosis of a seizure disorder and staff were trained on his seizure protocol, how to recognize a seizure and C4's had bedroom sound alert system during the night. The SMA also indicated C4 had a diagnosis of cerebral palsy which affects the muscles of his body and</p>	W 149		By 11/19/25 and ongoing

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W 149	<p>Continued From page 4</p> <p>required the use of a wheelchair. In addition, C4 had a neurogenic bladder which puts him at risk of incontinence, though most the time he was continent. The SMA further indicated he had a CPAP machine that staff are to check on four times during the evening/overnight to make visual check for mask in place and tubing as clear.</p> <p>C5's EDF dated 02/06/2025, indicated C5 had diagnosis of Schizoaffective disorder, mild intellectual disability, neuromuscular dysfunction of bladder (when nerve damage affects bladder control, leading to symptoms like incontinence or urinary retention).</p> <p>C5's IAPP dated 2/06/25, indicated C5 required 24-hour supervision. C5's SMA dated 2/06/25, indicated C5 was at risk for falls. The SMA indicated C5 was at risk of incontinence at night, may require verbal cue to use brief.</p> <p>C6's EDF dated 10/09/25, indicated she had diagnosis of profound intellectual disability, infantile cerebral palsy, bipolar disorder and constipation.</p> <p>C6's IAPP dated 3/12/25, indicated she required 24-hour staff supervision. C6 SMA dated 3/12/25, indicated her gait and balance was unsteady and could result in injury from falls or bumping into things and difficulty walking on uneven ground. Observation on 10/8/25, at 2:15 p.m. C6 was observed wearing a soft helmet walking around the home, continued to grab staffs' hand, leading staff to different locations.</p> <p>A Facility Reported Incident indicated on</p>	W 149		By 11/19/25 and ongoing

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W 149	<p>Continued From page 5</p> <p>10/03/25 at 11:23 p.m., the homes exterior cameras showed direct support professional (DSP)-A walk out of the front door of the house and got into a car, left the driveway at 11:26 p.m. and returned at 1:12 a.m. on 10/04/25. The report indicated door was left unlocked and the six vulnerable adults that lived at the home were left alone for approximately two hours. The incident was reported to the State Agency (SA) on 10/04/25 at 10:35 a.m. (over nine hours after the incident occurred).</p> <p>During interview on 10/08/25 at 2:10 p.m., program manager (PM) stated she was planning to talk with DSP-A on 10/03/25, related to complaints from day shift that clients were left soaked with urine in the morning. The PM said she was informed by dayshift staff how C2, C5 and C6 were found on 9/29/25, incontinent of urine, required bed changes and baths. In addition, the PM stated DSP-A was behind on her training and was not documenting in the home's computer program called Therap. The PM stated she had been texting and calling DSP-A with no response and felt it was best to show up at the home when she worked next. When asked why she allowed DSP-A to work another shift pending her investigation, PM indicated she wanted to give DSP-A a chance to hear her side of the story first. Then, on the night of 10/03/25 to 10/04/25, PM indicated she received an alert on her cell phone at 1:12 a.m. which showed DSP-A walking into the home and when she reviewed the camera footage further, she discovered DSP-A had left the house at 11:26 p.m. The PM stated she went to the home and arrived at 3:00 a.m. to first check on the clients and then spoke to DSP-A, who stated she</p>	W 149		By 11/19/25 and ongoing

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W 149	Continued From page 6 had an argument with her boyfriend and never left the driveway. The PM stated she believed this was not true as the camera footage showed her leaving in a car at 11:26 p.m. and then returning at 1:12 a.m. The PM stated she discussed her concerns with the incident on 9/29/25 and with DSP-A leaving the clients alone in the home and suspended her pending investigation. On 10/10/25 at 10:00 a.m. upon request, PM was unable to provide cell phone text message or call log record indicating DSP-A had been attempted to be contacted between 9/29/25 and 10/4/25.  During interview on 10/08/25 at 7:05 p.m., DSP-A stated she responded to a text from her PM on 9/26/25 related to getting access to the company's electronic documentation system (Therap), stating she could come in anytime that week but never received a response back from her. DSP-A state PM arrived at the house on 10/04/25, at 3:00 a.m. informing her cares were not being completed on the clients and then dismissed her from the shift due to leaving the clients alone during the night. DSP-A then stated she gets anxious during the night and on 10/03/25, her boyfriend came to talk since they had been going through some stuff; so, we talked and lost track of time. DSP-A stated on 10/03/25 he came to the house, and smoked weed (marijuana) from a vape pen but did not bring it into the home.  During interview on 10/09/25 at 11:34 a.m., assistant program manager (APM)-A stated she arrived to work on 9/29/25 at 6:00 a.m., and DSP-A was sitting on the couch relaxing and said all the clients were fine. APM-A stated when she	W 149		By 11/19/25 and ongoing	

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W 149	<p>Continued From page 7</p> <p>walked into the door the smell of urine was "so strong", you could smell urine all through the hallways upstairs and where C5's room was. C2's clothes and bed were soaking wet with urine which was unusual for him as he would call for help to use the toilet at night and would remain continent. In addition, APM stated C6 was soaking wet with urine, and they had to bring her to the toilet and all three of the clients required baths as well as all bedding needed to be completed changed and disinfected. APM-A stated she had never seen those clients so wet in the seven years she had worked at the home, and it seemed like DSP-A had not done anything the entire nightshift. APM-A indicated she and DSP-B both reported the allegation to the PM right away that morning and was directed to send an email to her. APM-A stated she was not aware of any concerns of DSP-A using drugs or alcohol while she was working.</p> <p>During interview on 10/09/25 at 11:56 a.m., DSP-B stated she arrived to work on 9/29/25 around 5:50 a.m., knocked on the door three times and rang the doorbell until finally DSP-A came to the door with a blanket wrapped around her. DSP-B stated she said the night went fine. DSP-B stated C2 was sitting on the edge of his bed, naked from the waist down and soaked with urine. Staff had to remove everything off his bed, including the mattress pad covering and disinfect the entire mattress. DSP-B stated based on how she found C2, she would assume C2 waited a long time to be assisted. DSP-B then stated she was shocked and had never seen anything like this before. In addition, DSP-B stated C5 was also completely soaked with urine including his bedding and even his pillow.</p>	W 149		By 11/19/25 and ongoing

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W 149	<p>Continued From page 8</p> <p>During a second interview on 10/09/25 at 2:27 p.m., PM approached surveyor and indicated she was not sure now how she contacted DSP-A but stated she called DSP-A using the home phone instead, again explaining she was planning on meeting with her during her shift on 10/3/25-10/4/25 but had fallen asleep. PM stated she did not report the alleged neglect to the SA since she was unable to contact DSP-A and felt she needed to complete an investigation first before reporting to the SA. The PM stated she informed the guardians of the incident that occurred on 10/04/25. PM-A stated she was shocked to find out DSP-A reported she had been using marijuana while working and was never informed of any concerns.</p> <p>During interview on 10/09/25 at 6:20 p.m., C5's guardians stated they were unaware of either incident and never received a phone call regarding them.</p> <p>During interview on 10/09/25 at 4:50 p.m., regional director (RD) stated she was aware of the incident related to lack of cares being provided by DSP-A during the night shift on 9/29/25, but was unaware of how serious it was, "I should have asked more questions when it was first brought to my attention." The RD stated she had a conversation with the PM, and it was decided then not to report the incident since there was no harm that occurred at the time. RD stated she did instruct her to investigate the incident, but it appears the PM may not have. In addition, the RD stated the incident that occurred on 10/03/25 to 10/04/25 with DSP-A of neglect to supervise, should have been reported</p>	W 149		By 11/19/25 and ongoing

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W 149	Continued From page 9 immediately according to policy and they have a no smoking policy at the home.  Vulnerable Adults Maltreatment Reporting and Internal Review Policy revised 2/18/25, indicated it is the policy of Living Well Disability Services to protect the adults served by this program who are vulnerable to maltreatment and to require the reporting of suspected maltreatment of vulnerable adults and upon knowledge of an incident of maltreatment, a report must be made to the Minnesota Adult Abuse Reporting Center (MAARC) immediately.	W 149		By 11/19/25 and ongoing	
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to report allegations of neglect to the state agency (SA ) for 3 of 3 clients (C2, C5 and C6) who did not receive incontinent cares and were found soaked with urine on 9/29/25, and 6 of 6 clients (C1, C2, C3 C4 C5 and C6 ) for an allegation of neglect to supervise, when clients were left alone in the home for approximately two hours.  Findings include:  C1's Emergency Data Form (EDF) dated 4/13/2020, indicated C1 had a diagnosis of	W 153	<b>W153 Staff Treatment of Clients CFR(s): 483.420(d)(2)</b> <b>a.</b> Immediately and going forward the Program Manager will ensure all allegations of mistreatment, neglect or abuse as well as injuries of unknown origin are immediately reported to the administrator or to other officials in accordance with state law through established procedures. <b>b.</b> The Program Manager will receive retraining to the organizational <i>Vulnerable Adults Maltreatment Reporting and Internal Review Policy</i> as well as the organizational <i>Incident Reporting and Review Policy</i> . Training to include but not be		

limited to adherence to implement all organizational policies and procedures by immediately reporting all incidents of mistreatment, neglect or abuse, serious injuries, death and injuries of unknown origin for any client, and specifically as it applies to incident of neglect for C2, C5 and C6. The Program Manager will ensure to immediately report all incidents of maltreatment, neglect and abuse to MAARC and to immediately notify the administrator (Regional Director) whenever notification of MAARC is implemented. Training for the Program Manager will also include the requirement for the Program Manager to address performance and conduct concerns of any employee as soon as possible when the Program Manager has knowledge that there is a performance concern regarding a specific employee and pertaining to the specific incident of neglect involving C2, C5 and C6 and pertaining to the incident when employee left the shift and all clients unattended and unsupervised. Retraining to occur by 11/7/25.

- c. The Program Manager will train Assistant Program Managers and shift leaders to follow the organizational procedures when the Program Manager is not on site at the time of any maltreatment, neglect or abuse incident. The Assistant Manager or shift leader will intervene when an incident of maltreatment, neglect or abuse occurs and request the specific employee leave the premises immediately. The Assistant Program Manager or shift leader will immediately notify the

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ongoing

<p>Program Manager of the incident that led to removal of an employee from any shift due to maltreatment, neglect or abuse as it applies to all clients and specifically C2, C5 and C6. Once the Program Manager has knowledge of the incident reported to them, the Program Manager will remove the employee from the working schedule and communicate to the employee that they cannot return to work or be scheduled for any shifts pending an internal investigation. Training to occur by 11/19/25.</p> <p>d. The Program Manager will monitor progress by using the organizational Quality Assurance tool known as Compass and specifically the Quality Improvement Work Plan.</p> <p>e. The Regional Director is responsible for overall compliance with this citation.</p>	<p>11/19/25 and ongoing ↓</p>
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NAME OF PROVIDER OR SUPPLIER  <b>LIVING WELL CENTRAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1555 CENTRAL AVENUE SOUTHWEST CAMBRIDGE, MN 55008</b>	

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W 153	<p>Continued From page 10 severe intellectual disability. C2's EDF dated 10/09/25, indicated C2 had diagnosis of moderate intellectual disability and a seizure disorder.</p> <p>C3's EDF dated 04/13/2020, indicated C4 had diagnosis of moderate intellectual disability.</p> <p>C4's EDF dated 10/14/25, indicated C4 had diagnosis of mild intellectual disability and a seizure disorder.</p> <p>C5's EDF dated 02/06/2025, indicated C5 had diagnosis of mild intellectual disability, neuromuscular dysfunction of bladder (when nerve damage affects bladder control, leading to symptoms like incontinence or urinary retention).</p> <p>C6's EDF dated 10/09/25, indicated C5 had diagnosis of profound intellectual disability, infantile cerebral palsy, bipolar disorder and constipation.</p> <p>During interview on 10/09/25 at 11:34 a.m., assistant program manager (APM)-A stated she arrived to work on 9/29/25 at 6:00 a.m., and DSP-A was sitting on the couch relaxing and said all the clients were fine. APM-A stated when she walked into the door the smell of urine was "so strong", you could smell urine all through the hallways upstairs and where C5's room was. C2's clothes and bed were soaking wet with urine which was unusual for him as he would call for help to use the toilet at night and would remain continent. In addition, APM stated C6 was soaking wet with urine, and they had to bring her to the toilet and all three of the clients required baths as well as all bedding needed to be</p>	W 153		By 11/19/25 and ongoing

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W 153	<p>Continued From page 11</p> <p>completed changed and disinfected. APM-A stated she had never seen those clients so wet in the seven years she had worked at the home, and it seemed like DSP-A had not done anything the entire nightshift. APM-A indicated she and DSP-B both reported the allegation to the PM right away that morning and was directed to send an email to her. APM-A stated she was not aware of any concerns of DSP-A using drugs or alcohol while she was working.</p> <p>During interview on 10/09/25 at 11:56 a.m., DSP-B stated she arrived to work on 9/29/25 around 5:50 a.m., knocked on the door three times and rang the doorbell until finally DSP-A came to the door with a blanket wrapped around her. DSP-B stated she said the night went fine. DSP-B stated C2 was sitting on the edge of his bed, naked from the waist down and soaked with urine. Staff had to remove everything off his bed, including the mattress pad covering and disinfect the entire mattress. DSP-B stated based on how she found C2, she would assume C2 waited a long time to be assisted. DSP-B then stated she was shocked and had never seen anything like this before. In addition, DSP-B stated C5 was also completely soaked with urine including his bedding and even his pillow.</p> <p>A Facility Reported Incident indicated on 10/03/25 at 11:23 p.m., the homes exterior cameras showed direct support professional (DSP)-A walk out of the front door of the house and got into a car, left the driveway at 11:26 p.m. and returned at 1:12 a.m. on 10/04/25. The reported indicated door was left unlocked and the six vulnerable adults that lived at the home were left alone for approximately two hours. The</p>	W 153		By 11/19/25 and ongoing

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W 153	Continued From page 12 incident was reported to the State Agency (SA) on 10/04/25 at 10:35 a.m. (over nine hours after the incident occurred)  During interview on 10/08/25 at 2:10 p.m., program manager (PM) stated she was informed by dayshift staff how C2, C5 and C6 were found on 9/29/25, incontinent of urine, required bed changes and baths. She indicated she reported the concern to her Regional Director (RD)-A the same day, but they did not determine it was reportable. Then, on the night of 10/03/25 to 10/04/25, PM indicated she received an alert on her cell phone at 1:12 a.m. which showed DSP-A walking into the home and when she reviewed the camera footage further, she discovered DSP-A had left the house at 11:26 p.m. The PM stated she went to the home and arrived at 3:00 a.m. to first check on the clients and then spoke to DSP-A, who stated she had an argument with her boyfriend and never left the driveway. The PM stated she believed this was not true as the camera footage showed her leaving in a car at 11:26 p.m. and then returning at 1:12 a.m. The PM stated she discussed her concerns with the incident on 9/29/25 and with DSP-A leaving the clients alone in the home and suspended her pending investigation. PM-A indicated she waited to report the incident until the following morning of 10/4/25. She stated she believed that was timely reporting.  During interview on 10/09/25 at 4:50 p.m., regional director (RD) stated she was aware of the incident related to lack of cares being provided by DSP-A during the night shift on 9/29/25, but was unaware of how serious it was, "I should have asked more questions when it was	W 153		By 11/19/25 and ongoing	

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W 153	Continued From page 13 first brought to my attention." The RD stated she had a conversation with the PM, and it was decided then not to report the incident since there was no harm that occurred at the time. RD stated she did instruct her to investigate the incident, but it appears the PM may not have. In addition, the RD stated the incident that occurred on 10/03/25 to 10/04/25 with DSP-A of neglect to supervise, should have been reported immediately according to policy.  Vulnerable Adults Maltreatment Reporting and Internal Review Policy revised 2/18/25, indicated it is the policy of Living Well Disability Services to protect the adults served by this program who are vulnerable to maltreatment and to require the reporting of suspected maltreatment of vulnerable adults and upon knowledge of an incident of maltreatment, a report must be made to the Minnesota Adult Abuse Reporting Center (MAARC) immediately.	W 153		By 11/19/25 and ongoing	
W 154	<b>STAFF TREATMENT OF CLIENTS</b> CFR(s): 483.420(d)(3)  The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview, observation and record review the facility failed to thoroughly investigate and protect clients from potential future neglect for 3 of 3 clients (C2, C5 and C6) who who did not receive incontinent cares and were found soaked with urine. In addition, direct support professional (DSP)-A was allowed to continue to work without a thorough investigation of the alleged neglect, which led to further neglect.  Findings include:	W 154	<b>W 154 Staff Treatment of Clients</b> <b>CFR(s): 483.420(d)(3)</b> a. Immediately and going forward, the Program Manager will conduct a thorough and immediate internal investigation into all alleged violations and protect clients from potential future neglect specifically as it applies to provision of immediate care to C2, C5, and C6 and regarding the incident involving all clients left unattended and unsupervised in the home. b. The Regional Director will provide re-training for the Program Manager regarding the organizational <i>Internal Investigation</i> procedure, documentation form and guidelines. Training to include but not be limited to once the Program Manager has knowledge of or receives any report of		

maltreatment, neglect and abuse and if the Program Manager has received reports from employees or has knowledge of any employee performance concerns involving maltreatment, neglect and abuse, the Program Manager will immediately initiate an internal investigation. The internal investigation will include but not be limited to all information obtained from conducting interviews of all employees and specifically all employees who witnessed or reported a specific incident (interviews will also include client interviews), and how to correctly conduct an internal investigation by determining if policies and procedures were followed, if the policies and procedures were adequate, if there is a need for additional staff training, if the reported event is similar to past events with the vulnerable adults or the services involved and if there is a need for corrective action by the organization to protect the health and safety of vulnerable adults. The Regional Director will also provide training regarding the deadline for completing an internal investigation, which is 5 calendar days. Training to occur by 11/7/25.

- c. The Program Manager will notify and document by use of an internal investigation report, when the team members are notified of an incident of maltreatment, neglect and abuse. The internal investigation and any additional documents will be reviewed by Regional Director and Director of Program Services and kept on file.
- d. The Program Manager will

11/19/25  
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ongoing  
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<p>maintain documentation of any incident involving notification of MAARC and subsequent internal investigation documentation. Program Manager and Human Resources at Living Well will retain documentation of any disciplinary action provided to any employee who is involved in any incident of maltreatment, abuse or neglect.</p> <p>e- The Program Manager will retrain all employees to the <i>Vulnerable Adults Maltreatment Reporting and Internal Review Policy</i> as well as the organizational <i>Incident Reporting and Review Policy</i> specifically as the policies pertain to identifying the type of situations which constitute reporting and to review the requirement to immediately report any incident of maltreatment, neglect or abuse by any employee to any client to the Program Manager. Training for all employees will occur by 11/19/25.</p> <p>f- The Program Manager will monitor progress by using the organizational Quality Assurance tool known as Compass and specifically the Quality Improvement Work Plan.</p> <p>g- The Regional Director is responsible for overall compliance for this citation.</p>	<p>11/19/25 and ongoing ↓</p>
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W 154	<p>Continued From page 14</p> <p>C2's EDF dated 10/09/25, indicated C2 had diagnosis of moderate intellectual disability and a seizure disorder.</p> <p>C5's EDF dated 02/06/2025, indicated C5 had diagnosis of mild intellectual disability, neuromuscular dysfunction of bladder (when nerve damage affects bladder control, leading to symptoms like incontinence or urinary retention).</p> <p>C6's EDF dated 10/09/25, indicated C5 had diagnosis of profound intellectual disability, infantile cerebral palsy, and bipolar disorder.</p> <p>During interview on 10/09/25 at 11:34 a.m., assistant program manager (APM)-A stated she arrived to work on 9/29/25 at 6:00 a.m., and DSP-A was sitting on the couch relaxing and said all the clients were fine. APM-A stated when she walked into the door the smell of urine was "so strong", you could smell urine all through the hallways upstairs and where C5's room was. C2's clothes and bed were soaking wet with urine which was unusual for him as he would call for help to use the toilet at night and would remain continent. In addition, APM stated C6 was soaking wet with urine, and they had to bring her to the toilet and all three of the clients required baths as well as all bedding needed to be completed changed and disinfected. APM-A stated she had never seen those clients so wet in the seven years she had worked at the home, and it seemed like DSP-A had not done anything the entire nightshift. APM-A indicated she and DSP-B both reported the allegation to the PM right away that morning and was directed to send an email to her. APM-A stated she was not</p>	W 154		By 11/19/25 and ongoing

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W 154	<p>Continued From page 15</p> <p>aware of any concerns of DSP-A using drugs or alcohol while she was working.</p> <p>During interview on 10/09/25 at 11:56 a.m., DSP-B stated she arrived to work on 9/29/25 around 5:50 a.m., knocked on the door three times and rang the doorbell until finally DSP-A came to the door with a blanket wrapped around her. DSP-B stated she said the night went fine. DSP-B stated C2 was sitting on the edge of his bed, naked from the waist down and soaked with urine. Staff had to remove everything off his bed, including the mattress pad covering and disinfect the entire mattress. DSP-B stated based on how she found C2, she would assume C2 waited a long time to be assisted. DSP-B then stated she was shocked and had never seen anything like this before. In addition, DSP-B stated C5 was also completely soaked with urine including his bedding and even his pillow.</p> <p>During interview on 10/08/25 at 2:10 p.m., program manager (PM) stated she was planning to talk with DSP-A on 10/03/25, related to complaints from day shift that clients were left soaked with urine in the morning. The PM said she was informed by dayshift staff how C2, C5 and C6 were found on 9/29/25, incontinent of urine, required bed changes and baths. In addition, the PM stated she had been texting and calling DSP-A with no response and felt it was best to show up at the home when she worked next (10/3/25). When asked why she allowed DSP-A to work another shift pending her investigation, PM indicated she wanted to give DSP-A a chance to hear her side of the story first. Then, on the night of 10/03/25 to 10/04/25, PM indicated she received an alert on her cell</p>	W 154		By 11/19/25 and ongoing

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W 154	<p>Continued From page 16</p> <p>phone at 1:12 a.m. which showed DSP-A walking into the home and when she reviewed the camera footage further, she discovered DSP-A had left the house at 11:26 p.m. The PM stated she went to the home and arrived at 3:00 a.m. to first check on the clients and then spoke to DSP-A, who stated she had an argument with her boyfriend and never left the driveway. The PM stated she believed this was not true as the camera footage showed her leaving in a car at 11:26 p.m. and then returning at 1:12 a.m. The PM stated she discussed her concerns with the incident on 9/29/25 and with DSP-A leaving the clients alone in the home and suspended her pending investigation.</p> <p>During a second interview on 10/09/25 at 2:27 p.m., PM approached surveyor and indicated she was not sure now how she contacted DSP-A but stated she called DSP-A using the home phone instead, again explaining she was planning on meeting with her during her shift on 10/3/25-10/4/25 but had fallen asleep. PM stated she did not report the alleged neglect to the SA since she was unable to contact DSP-A and felt she needed to complete an investigation first before reporting to the SA. PM-A stated she was shocked to find out DSP-A reported she had been using marijuana while working and was never informed of any concerns.</p> <p>On 10/10/25 at 10:00 a.m. upon request, PM was unable to provide cell phone text message or call log record indicating DSP-A had been attempted to be contacted between 9/29/25 and 10/4/25.</p> <p>During interview on 10/09/25 at 4:50 p.m., regional director (RD) stated she was aware of</p>	W 154		By 11/19/25 and ongoing

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W 154	Continued From page 17 the incident related to lack of cares being provided by DSP-A during the night shift on 9/29/25, but was unaware of how serious it was, "I should have asked more questions when it was first brought to my attention." The RD stated she had a conversation with the PM, and it was decided then not to report the incident since there was no harm that occurred at the time. RD stated she did instruct her to investigate the incident, but it appears she may not have.  Vulnerable Adults Maltreatment Reporting and Internal Review policy revised 2/18/2025, indicated:  1. When Living Well Disability Services has reason to know that an internal or external report of alleged or suspected maltreatment has been made, the organization must complete an internal review and take corrective action, if necessary, to protect the health and safety of vulnerable adults. 2. The internal review must include an evaluation of whether: a. related policies and procedures were followed. b. the policies and procedures were adequate. c. there is a need for additional staff training. d. the reported event is similar to past events with the vulnerable adults or the services involved. e. there is a need for corrective action by the organization to protect the health and safety of vulnerable adults. 3. The internal review must be completed within 5 working days.	W 154		By 11/19/25 and ongoing	