

Protecting, Maintaining and Improving the Health of All Minnes ot ans

Electronically Delivered Via Email October 21, 2020

Administrator Shingle Creek Option 5624 73rd Ave No Brooklyn Park, MN 55429

RE: VXJR11

Project Number: HG382004C

Dear Administrator:

On September 23, 2020 through September 30, 2020, an abbreviated survey was conducted to investigate complaint HG382004C. The complaint was substantiated and deficiencies.

In addition, the Condition of Participation- health care services services was found not to be in compliance with 42 CFR 483.460.

W318 42 CFR § 483.420 Health Care Services

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

Shingle Creek Option

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- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

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

Gail Anderson, APM
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Office: (218) 332-5140

Shingle Creek Option

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Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by **November 14, 2020**, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

Sincerely,

Any Johour

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed October 21, 2020

Administrator Shingle Creek Option 5624 73rd Ave No Brooklyn Park, MN 55429

Re: Enclosed State Supplemental Nursing Services Agency Orders - Project Number HG382004C Event ID: VXJR11

Dear Administrator:

On September 23, 2020 - September 30, 2020, a complaint investigation was conducted. The following complaint(s) was found to be substantiated: HG382004C.

Your facility is not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).

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

Please feel free to call me with any questions.

Sincerely,

Any Johour

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ С B. WING 01430 09/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO SHINGLE CREEK OPTION BROOKLYN PARK, MN 55429 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 5 000 5 000 Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 9/23/20 - 9/30/20, a complaint investigation was conducted. The following complaint(s) was found to be substantiated: HG382004C. Your facility is not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). 5 825 MN Statute 626,557 Subd. 4, VA Reporting. 5 825

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Whill Il

TITLE

(X6) DATE

STATE FORM

6899

VXJR11

If continuation sheet 1 of 5

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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	A mandated reported oral report to the contelecommunications similar device shall. The common entry reports. To the extended of sufficient contended adult, the caregiver, suspected maltreatment the reporter, the time incident, and any off reporter believes mit the suspected maltreporter may disclosin section 13.02, and	er shall immediately make an ammon entry point. Use of a sidevice for the deaf or other be considered an oral report. point may not require written not possible, the report must ent to identify the vulnerable the nature and extent of the ment, any evidence of ent, the name and address of e, date, and location of the mer information that the ght be helpful in investigating eatment. A mandated se not public data, as defined a medical records under the extent necessary to				
	by: Based on interview a agency failed to noti client to to client abu (C2,C4,C5) reviewed	L L		-		-
	Finding include:	on 2000 Housest - Mari				
	aggressive behavior Services Assessmer 2019 - September 20 affecting her ability to history of throwing be books/magazines. A review of C2's Accidated 6/2020-9/2020	an 2020, identified a history of s. C2's Intensive Support of (ISSA) dated September 020, identified behaviors of self manage including a powels, plates, phones and ident and Incident Reports of identified the following:				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 01430 09/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO SHINGLE CREEK OPTION BROOKLYN PARK, MN 55429 SUMMARY STATEMENT OF DÉFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY 5 825 5 825 Continued From page 2 5 825 The facility's Vulnerable Adults Abuse shoved the client into a cabinet. Preventative measures included, keep a closer eye on C2 Prevention Plan will be updated to when there is only one staff in the apartment. specify that all incidents of verbal or physical aggression between clients will 7/8/20, C2 had been anxious and was sitting in a be immediately reported to the QIDP. chair. Another Client (C5) was looking out the window. C2 stood up and pushed C5 into an arm regardless of amount of harm caused. chair. C5 moved behind the chair to get away The policy will direct the QIDP to report from C2. Preventative measures included, keep all incidents of verbal or physical others away from her when she is in an anxious aggression to the state agency. All staff affect. will receive a copy of the updated policy 7/9/20, C2 was sitting in a chair, C4 walked by and retraining on the updated and C2 pushed C4 with one hand, C4 stumbled 11/14/200 procedure by 11/12/20. New staff will and walked away. Preventative measures included, keep's close eye on C2 when peers receive a copy of the updated policy as: were around. part of their initial intake at Alternatives for People with Autism (Alternatives). 7/12/20, C2 came out of her room to use the and will be trained on the updated bathroom. Another client walked by and C2 pushed the client. Preventative measures Vulnerable Adults Abuse Prevention included, try to re-direct C2 while creating a shield Plan prior to working their first direct for anyone who walked by. care shift. 7/13/20, C4 was walking around the apartment. The updated Vulnerable Adults Abuse C2 pushed him with two hands into the counter. Prevention Plan will be reviewed on a Preventative measures included, keep a close eye on C2 and her distance from other individuals quarterly basis by the QIDP and the in the apartment. Human Rights Committee, to ensure its continued efficacy. If failures in the 7/15/20, C5 wandered near C2 and C2 pushed C5. Preventative measures included, continue to reporting of verbal or physical keep close eye on where res are in relation to C2. aggression are found at that time, or any other time between scheduled 7/18/20, As C2 was walking to her chair, C5 reviews, the QIDP will be responsible walked in front of her. C2 pushed C5 with two hands in the chest. Preventative measures for addressing these deficiencies with a included, stay close to aggressing clients so they revised Vulnerable Adults Abuse don't reach each other in the apartment. Prevention Plan within three days of

the discovery of the deficiency.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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5 825	Continued From page	ge 3	5 825			
	When walking to he client into the table.	ing directed to her chair. r chair C2 pushed another Preventative measures walk with C2 all the way to				
	8/9/20, C2 was direct had an ATO (aggress who was seated next	cted to stay in her seat and sion toward others) on C4 of to her.				
	shoulder causing cli Preventative measu	another client on the right ent to fall to the floor. res included, shadow C2 een her and other peers.				
	9/20/20, C2 charged into the wall with two	toward C4 and pushed him hands.				
	2:00 p.m. program n sometimes C2 had a and there was a lot g would aggress again stated for the most p stated if C2 was about her to sit down and u stated other times C2 two handed pushed PM-B stated she was fallen as a result of C2	9/24/20, at approximately nanager (PM)-B stated aggression when it was loud going on. PM-B stated C2 ast staff or other clients and part it was pretty mild. PM-B at to "charge" staff would tell usually that worked. The PM 2 would aggress and one or or may charge at someone. It is unaware if any clients had c2's aggression but stated any injuries to other clients.				
	disability professional "temporary interruption got aggressive. The otherwise themselves between directed her to sit in h	o.m. the qualified intellectual I (QIDP) stated "C2 had a con procedure" for when she QIDP stated staff put C2 and other clients and her chair. The QIDP stated if thair staff would basically				

PRINTED: 10/20/2020 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 01430 09/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO SHINGLE CREEK OPTION **BROOKLYN PARK, MN 55429** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 825 Continued From page 4 5 825 On 9/25/20, at 1:44 p.m. the QIDP stated the incidents of aggression between C2 and other clients had not been reported to the SA. The QIDP stated a report was not required unless there was an injury as a result of an altercation. The QIDP stated if there was no injury, then no report was needed. A facility policy titled Vulnerable Adults Abuse Prevention Plan, Internal Reporting System undated, indicated verbal or physical aggression between clients does not constitute abuse unless the behavior causes serious harm.

Minnesota Department of Health

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	conducted to invest The complaint was	20, an abbreviated survey was tigate complaint HG382004C. substantiated and deficiencies , W336, W149, W153		Sharen	
		dition of Participation- health ces was found not to be in CFR 483.460.		received 11/4/20 approved 11/10/20 POC 11/4/20	
W 149	•		W 14	W149	
	policies and proced	velop and implement written ures that prohibit ect or abuse of the client.		The facility's Vulnerable Adults Abu Prevention Plan will be updated to specify that all incidents of verbal o physical aggression between clients	r s will
	Based on interview facility failed to deve prevention policy whi immediately report	s not met as evidenced by: and document review, the elop a facility abuse nich directed staff to client to client abuse for 1 of 3 ad who displayed physically rs towards others.		be immediately reported to the QID regardless of amount of harm cause. The policy will direct the QIDP to re all incidents of verbal or physical aggression to the state agency. All s will receive a copy of the updated p and retraining on the updated	ed. port staff
	Findings include:			procedure by 11/12/20. New staff verceive a copy of the updated policy	1
***	Prevention Plan, Intundated, indicated	Vulnerable Adults Abuse ernal Reporting System verbal or physical aggression as not constitute abuse unless as serious harm.		part of their initial intake at Alternatives and will be trained on the updated	tives
	A review of C2's Acc	cident and Incident Reports 0 identified the following:		(continued o	over)
ABORATORY		ER/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	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.

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A BUILDING			(X3) DATE SURVEY COMPLETED		
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	-6/25/20, C1 charge shoved the client in measures included, when there is only of -7/8/20, C2 had been chair. Another clien window. C2 stood unchair. C5 moved be from C2. Preventate others away from heaffect. -7/9/20, C2 was sittly and C2 pushed C4 and walked away. Fincluded, keep sick were around. -7/12/20, C2 came of bathroom. Another of pushed the client. Fincluded, try to re-differ anyone who walked away. Fincluded, try to re-differ anyone who walked the client. Fincluded, try to re-differ anyone who walked. The pushed him with Preventative measure eye on C2 and her continued in the apartment. -7/15/20, C5 wander C5. Preventative measure eye on C2 and her continued in the apartment.	ed at another client (C4) and to a cabinet. Preventative keep a closer eye on C2 one staff in the apartment. en anxious and was sitting in a t (C5) was looking out the p and pushed C5 into an arm hind the chair to get away ive measures included, keep er when she is in an anxious one in a chair, C4 walked by with one hand. C4 stumbled be eye on C2 when peers one eye on C2 when peers out of her room to use the client walked by and C2 or eventative measures rect C2 while creating a shield	W 149	(W149 cont.) Vulnerable Adults Prevention Plan prior to working first direct care shift. The updated Vulnerable Adults Prevention Plan will be reviewed quarterly basis by the QIDP and Human Rights Committee, to econtinued efficacy. If failures in reporting of verbal or physical aggression are found at that tirrany other time between schedular reviews, the QIDP will be responsed for addressing these deficiencies revised Vulnerable Adults Abus Prevention Plan within three dathed discovery of the deficiency.	s Abuse ed on a d the ensure its n the me, or uled ensible es with a e	11/14/202

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		ected to stay in her seat and				
		ssion toward others) on C4				
	who was seated nex	xt to her.				
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		d another client on the right ent to fall to the floor.				
		res included, shadow C2				
		een her and other peers.			,	
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		d toward C4 and pushed him				
	into the wall with two	hands.		·		
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ļ		9/24/20, at approximately			•	
1		manager (PM)-B stated				
		aggression when it was loud going on. PM-B stated C2				
		against staff or other clients				
		ost part it was pretty mild.				
		as about to "charge," staff				
		lown and usually that worked.				
	The PM stated other	times C2 would be				
		or two handed pushed or]
		one. PM-B stated she was				Ì
		ts had fallen as a result of				
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	any injuries to other	clients.				
	On 9/24/20, at 2:51 r	o.m. the qualified intellectual				
		al (QIDP) stated "C2 had a		~	į	1
		on procedure" for when she				
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	directed her to sit in	n C2 and other clients and her chair. The QIDP stated if chair staff would basically	·	•	i	,
	incidents of aggress clients had not been QIDP stated the ago report incidents of c the SA unless some	p.m. the QIDP stated the sion between C2 and other in reported to the SA. The ency was not required to lient to client altercations to sone was injured. The QIDP no injury, then no report was				
W 153	STAFF TREATMEN CFR(s): 483.420(d)		W 153	W153		
	The facility must ensistreatment, negle injuries of unknown immediately to the a	sure that all allegations of ct or abuse, as well as source, are reported idministrator or to other ce with State law through		The facility's Vulnerable Adults Abu Prevention Plan will be updated to direct the QIDP to report all incider verbal or physical aggression to the state agency, regardless of the amo of harm caused. All staff will receiv copy of the updated policy and	nts of	
	Based on interview agency failed to noti client to to client abu (C2,C4,C5) reviewed	ı		retraining on the updated procedure 11/12/20. New staff will receive a confithe updated policy as part of the initial intake at Alternatives and will trained on the updated Vulnerable	opy ir	
	Finding include:			Adults Abuse Prevention Plan prior	to	
	aggressive behavior Services Assessmer 2019 - September 2 affecting her ability to	an 2020, identified a history of s. C2's Intensive Support nt (ISSA) dated September 020, identified behaviors o self manage including a owels, plates, phones and		working their first direct care shift.	over)	

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W 15	books/magazines. A review of C2's Acc dated 6/2020-9/202 6/25/20, C1 charger shoved the client in measures included, when there is only of 7/8/20, C2 had beer chair. Another Client window. C2 stood unchair. C5 moved be from C2. Preventate others away from heaffect. 7/9/20, C2 was sitting and C2 pushed C4 wand walked away. Fincluded, keep sick were around. 7/12/20, C2 came of bathroom. Another of pushed the client. Fincluded, try to rediffer anyone who walk 7/13/20, C4 was walk C2 pushed him with Preventative measureye on C2 and her din the apartment.	cident and Incident Reports 0 identified the following: d at another client (C4) and to a cabinet. Preventative keep a closer eye on C2 one staff in the apartment. In anxious and was sitting in a at (C5) was looking out the p and pushed C5 into an arm hind the chair to get away ive measures included, keep or when she is in an anxious ag in a chair, C4 walked by with one hand. C4 stumbled Preventative measures use eye on C2 when peers aut of her room to use the client walked by and C2 Preventative measures rect C2 while creating a shield	W 15	(W153 cont.) The updated Vul Adults Abuse Prevention Plan reviewed on a quarterly basis QIDP and the Human Rights Co to ensure its continued efficac failures in the reporting of ver physical aggression are found time, or any other time betwe scheduled reviews, the QIDP w responsible for addressing the deficiencies with a revised Vul Adults Abuse Prevention Plan three days of the discovery of deficiency.	will be by the committee, y. If bal or at that en vill be se nerable within	11/14/20

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION			E SURVEY IPLETED
		24G382	B. WING				C 30/2020
	PROVIDER OR SUPPLIER CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP CO 5624 73RD AVE NO BROOKLYN PARK, MN 55429	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD !	BE	(X5) COMPLETION DATE
W 153	7/18/20, As C2 was walked in front of he hands in the chest, included, stay close don't reach each of 7/30/20, C2 was be When walking to he client into the table, included, staff must chair. 8/9/20, C2 was dire had an ATO (aggres who was seated newho was a lot would aggress againstated for the most stated if C2 was abounded newho was seated other times C2 was abounded newho was seated she was a lot would aggress againstated of the most stated if C2 was abounded newho was seated newho was seate	swalking to her chair, C5 er. C2 pushed C5 with two Preventative measures to aggressing clients so they her in the apartment. Ing directed to her chair. For chair C2 pushed another Preventative measures walk with C2 all the way to cted to stay in her seat and ssion toward others) on C4 xt to her. I another client on the right ient to fall to the floor. For included, shadow C2 For her and other peers. I d toward C4 and pushed him to hands. 9/24/20, at approximately manager (PM)-B stated aggression when it was loud going on. PM-B stated C2 Inst staff or other clients and part it was pretty mild. PM-B out to "charge" staff would tell usually that worked. The PM C2 would aggress and one or or may charge at someone. Is unaware if any clients had	W 1				
		C2's aggression but stated any injuries to other clients.					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING			TE SURVEY MPLETED		
		240292	B. WING		:	С
NAME OF	PROVIDER OR SUPPLIER	24G382	B. WING			/30/2020
SHINGLE CREEK OPTION				STREET ADDRESS, CITY, STATE, ZIP COI 5624 73RD AVE NO BROOKLYN PARK, MN 55429	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AR DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 153	On 9/24/20, at 2:51 disability profession "temporary interrup got aggressive. The themselves betwee directed her to sit in C2 did not sit in her barricade her. On 9/25/20, at 1:44 incidents of aggress clients had not beer QIDP stated a report here was an injury. The QIDP stated if treport was needed. A facility policy titled Prevention Plan, Intundated, indicated whether the behavior causes HEALTH CARE SEF CFR(s): 483.460 The facility must enservices requirement.	p.m. the qualified intellectual pal (QIDP) stated "C2 had a tion procedure" for when she a QIDP stated staff put in C2 and other clients and inher chair. The QIDP stated if chair staff would basically p.m. the QIDP stated the sion between C2 and other in reported to the SA. The interported to the SA. The interported to an altercation, there was no injury, then no vulnerable Adults Abuse ernal Reporting System verbal or physical aggression is not constitute abuse unless a serious harm. RVICES sure that specific health care into are met. In of Participation at 42 CFR is services was not met. The ure thorough assessment	W 1	Alternatives will complete a comprehensive assessment or all residents for whom falling risk by 11/12/20, or within tendays of a newly emerging falling whether permanent or tempor comprehensive assessments with completed by the RN. Whene findings of an assessment suglimplementation of an interves intervention established at the and all direct-care staff who with the affected client will be train new intervention prior to worthat resident. Whenever the assessment establishes a need change to the physical environment at the QIDP will be responsible for initiating the change in the physical environment at that time. The efficacy of the intervention assessed on a quarterly basis of following significant changes in mobility of a client. If at that the interventions are judged to be insufficient to reduce the risk of another assessment will be considered.	is a known in calendar ing risk, orary. The will be wer the gest the intion, that at time work with ined in the king with in differ a in the intion, in the ime the intion or in the ime the infalling, inducted	11/14/202
	and implementation of interventions to reduce the likelihood of falls for 1 of 1 clients (C1) reviewed for Falls.			within two weeks of that judge and modified, or new interven established.		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	(X3) DATE SU COMPLE	
		24G382	B. WING		C	0000
MAME OF	PROVIDER OR SUPPLIER	240002	B. W.110	STREET ADDRESS, CITY, STATE, ZIP CODE	09/30/	2020
SHINGLE CREEK OPTION				5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CO	(X5))MPLETION DATE
W 318	Continued From pa	ge 7	W 318	3		
	Findings include:					
W 331	implement practices 1 of 1 clients (C1) ro NURSING SERVIC CFR(s): 483.460(c) The facility must pro	·	W 331	Alternatives will complete a comprehensive assessment of falls all residents for whom falling is a ki	nown	
	Based on observat review, the agency comprehensive ass develop and implem	essment of falls and failed to nent interventions to reduce is for 1 of 1 clients (C1)		risk by 11/12/20, or within ten cale days of a newly emerging falling ris whether permanent or temporary. comprehensive assessments will be completed by the RN. Whenever the findings of an assessment suggest to implementation of an intervention,	k, The e he	
	Findings include:			intervention established at that tim	e '	
	(ISSA) dated 9/10/1 coordination along we placed him at risk if indicated C1 had a placed at which time recommended to cowhen walking long of the physical therap	ntrol speed and offer support listances or in the community. y assessment also indicated of shower for bathing. The		and all direct-care staff who work we the affected client will be trained in new intervention prior to working we that resident. Whenever the assessment establishes a need for a change to the physical environment the QIDP will be responsible for initiating the change in the physical environment at that time.	the //	
		ncident Reports dated 6/22/20 C1 experienced a total of 25		(continued o	ver)	

LAMB DEAN OF CODDECTION INDESTREE INDESTRUCTION NUMBER			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		24G382	B. WING		00	C 0/30/2020	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		13012020	
SHINGL	E CREEK OPTION			5624 73RD AVE NO BROOKLYN PARK, MN 55429			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 331	-6/22/20, C1 was at missed the chair an included, monitor C -6/30/20, C1 was stand slipped to his boon the arm rest of the measures included, morning when using -7/10/20, C1 walked heard a thump and bottom. Preventative monitor C1 when go -7/12/20, C1 stood ustarted walking, lost bottom. C1 hit his baneck on the wall. Preshadowing C1 close apartment7/17/20, Staff were hammock and C1 lo C1 to the ground hor Preventative measures taff when putting C -7/21/20, C1 was ware and started to fall. Si -7/30/20, C1 stood us his bottom. Preventative measures hadow C1 closely was and control of the control o	tempting to sit at the table, d fell. Preventative measures 1 closely for imbalance. anding up from the commode ottom. C1 scraped his elbowne commode. Preventative monitor C1's gait in early grommode. I into his room for a nap. Staff found him on the floor on his emeasures included, closely bing into his room alone. up from his chair abruptly, his balance and fell on his ack, shoulder blades and eventative measures included ally when moving in the st his balance. Staff lowered	W 3:	(W331 cont.) The efficacy of interventions will be assesse quarterly basis or following schanges in the mobility/stab client. If at that time the inteare judged to be insufficient the risk of falling, another as will be conducted within two that judgement and modified interventions established.	d on a significant ility of a erventions to reduce sessment o weeks of	11/14/2-2	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED
	,	24G382	B. WING			ne	C /30/2020
	PROVIDER OR SUPPLIER E CREEK OPTION			5	STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	8E	(X5) COMPLETION DATE
W 331	and lost his balance	ge 9 ting clothes out of his closet and fell. C1 then fell a staff were trying to assist him	W 3	331			
-	chair. Preventative i	empting to sit on a kitchen neasures included, consider instead of brown shoes.					
	entered his room ar floor was wet so sta Preventative measu	on sensor sounded and staff and found C1 on the floor. C1's ff assumed he slipped. res included, C1 may need a to provide more grip when opriate urination.					
	slipped off and he tr his knees. Preventa	from a chair, C1's shoe ipped forward and landed on tive measures included, hen he got up quickly.					
	bed, slipped on the his knees. Preventa	alking in his room toward his ile floor and fell forward onto tive measures included alking on slippery flooring.			•		
	Preventative measu	one in his room when he fell. res included, floor would be avoid slippery surface.					
	from C1's room. Sta of his bedroom. Staf fell three more times get their footing. C1' Preventative measur floor for urine and m	I loud vocalizations coming If found C1 sitting on the floor If tried to assist him up and he If due to staff not being able to If staff not being and fell.					
	Gradiato, Or got up	THE LATE TO DESTRUCT STREET SELECT		[<u> </u>

NAME OF PROVIDER OR SUPPLIER SHINGLE CREEK OPTION SUMMANY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREVENT TAG SUMMANY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) W 331 Continued From page 10 Preventative measures included, monitor C1 closely, 9/3/20, C1's motion sensor sounded and he was found sitting on the floor in urine. Preventative measures included, closely monitor C1 when he woke up on the overnight shift. -9/4/20, C1 was ambulating, bumped into another client and fell and and bumped his head. Preventative measures included, dishedow C1 closely when moving around. -9/8/20, C1 was was liking with staff from the balthroom, tripped and fell. -9/12/20, C1 fell coming out of the shower. Preventative measures included, diff yelloor of balthroom for him. -9/13/20, C1 was sealed at the dining table and fell with the chair cnto his right side. Staff were unsure what caused the fall. Preventative measures included, make sure he was seated sturdly at all times. -9/13/20, C1 was brought to the hospital on Sunday by two staff after staff noticed a swollen right foot and confusion during the morning. -9/13/20, C1 was brought to the hospital on Sunday by two staff after staff noticed a swollen right foot and confusion during the morning. -9/13/20, Staff observed heavy redness around C1's right ear. Staff suspected he had fallen and hit his head on an object. Preventative measures included, he sure to check for injury thoroughly, several times per day.	STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED	
SHINGLE CREEK OPTION SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC DERTIFYING INFORMATION) W 331 Continued From page 10 Preventative measures included, monitor C1 closely. 9/3/20, C1's motion sensor sounded and he was found stitting on the floor in urine. Preventative measures included, shadow C1 closely when moving around. 9/8/20, C1 was ambulating, bumped into another client and fell and and bumped his head. Preventative measures included, shadow C1 closely when moving around. 9/8/20, C1 was walking with staff from the bathroom, tripped and fell. 9/9/20, C1 was in the bathroom with staff, slipped and fell. 9/9/20, C1 was seated at the dining table and fell with the chair onto his right side. Staff were unsure what caused the fall. Preventative measures included, make sure he was seated sturdily at all times. 9/13/20, C1 was brought to the hospital on Sunday by two staff after staff noticed a swollen right foot and confusion during the moming. 9/13/20, Staff observed heavy redness around C1's right ear. Staff suspected he had fallen and hit his head on an object. Preventative measures included, be sure to check for injury thoroughly,			24G382			0		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W 331 Continued From page 10 Preventative measures included, monitor C1 closely. 9/3/20, C1's motion sensor sounded and he was found sitting on the floor in urine. Preventative measures included, closely monitor C1 when he woke up on the overnight shift. -9/4/20, C1 was ambulating, bumped into another client and fell and and bumped his head. Preventative measures included, shadow C1 closely when moving around. -9/8/20, C1 was walking with staff from the bathroom kiripped and fell. -9/9/20, C1 was in the bathroom with staff, slipped and fell. -9/12/20, C1 fell coming out of the shower. Preventative measures included, dry floor of bathroom for him. -9/13/20, C1 was seated at the dining table and fell with the chair nonto his right side. Staff were unsure what caused the fall. Preventative measures included, make sure he was seated sturdily at all times. -9/13/20, C1 was brought to the hospital on Sunday by two staff after staff noticed a swollen right foot and confusion during the morning. -9/19/20, Staff observed heavy redness around C1's right ear. Staff suspected he had fallen and hit his head on an object, Preventative measures included, be sure to check for injury thoroughly,					5624 73RD AVE NO		3/30/2020	
Preventative measures included, monitor C1 closely. 9/3/20, C1's motion sensor sounded and he was found sitting on the floor in urine. Preventative measures included, closely monitor C1 when he woke up on the overnight shift. -9/4/20, C1 was ambulating, bumped into another client and fell and and bumped his head. Preventative measures included, shadow C1 closely when moving around. -9/8/20, C1 was walking with staff from the bathroom, tripped and fell. -9/9/20, C1 was in the bathroom with staff, slipped and fell. -9/12/20, C1 fell coming out of the shower. Preventative measures included, dry floor of bathroom for him. -9/13/20, C1 was seated at the dining table and fell with the chair onto his right side. Staff were unsure what caused the fall. Preventative measures included, make sure he was seated sturdily at all times. -9/13/20, C1 was brought to the hospital on Sunday by two staff after staff noticed a swollen right foot and confusion during the morning. -9/19/20, Staff observed heavy redness around C1's right ear. Staff suspected he had fallen and hit his head on an object. Preventative measures included, be sure to check for injury thoroughly,	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP	HOULD BE	COMPLETION	
		Preventative measur closely. 9/3/20, C1's motion found sitting on the measures included, woke up on the over -9/4/20, C1 was amt client and fell and ar Preventative measur closely when moving -9/8/20, C1 was wall bathroom, tripped ar -9/9/20, C1 was in the slipped and fell. -9/12/20, C1 fell compreventative measur bathroom for him. -9/13/20, C1 was seafell with the chair ont unsure what caused measures included, it sturdily at all times. -9/13/20, C1 was bro Sunday by two staff aright foot and confusitive foot and confusitive foot and confusitive foot and on an objincluded, be sure to confusite foot sure to confusite foot and confusitive foot and c	sensor sounded and he was floor in urine. Preventative closely monitor C1 when he rnight shift. bulating, bumped into another and bumped his head. res included, shadow C1 g around. king with staff from the and fell. he bathroom with staff, hing out of the shower. res included, dry floor of ated at the dining table and to his right side. Staff were the fall. Preventative make sure he was seated hught to the hospital on after staff noticed a swollen fon during the morning. I wed heavy redness around uspected he had fallen and ject. Preventative measures sheck for injury thoroughly,	W 33	31			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	CON	TE SURVEY MPLETED
		24G382	B. WING	<u> </u>	1	/30/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	thump and found his measures included his room. Review of C1's Hos dated 9/15/20 indicated 9/15/20 indicated falls in the last 24 indicated C1 had be and evaluation and with recommendatic staff to monitor and times. During observation skills instructor (LSI bathroom, LSI-A lef briefly, then returne	his room alone. Staff heard a m on the floor. Preventative monitor C1 closely when in spital Discharge Summary, ated C1 had autism, was deaf, rienced an increased number hours. The summary een admitted for observation was diagnosed with a stroke, on from physical therapy for assist with ambulation at all on 9/24/20, at 9:54 a.m. living the control of the total total and the diagnosed with a stroke, and the control of the total control of the total one diagnosed with a towel. At 10:11 a.m.	W 331			
	was wearing a tower Wet foot prints were leading out into the C1 ambulated to the onto the back of his During interview on member (FM)-A sta and stated he/she fiwith him on that. FM belt they were using about the belt last y During interview on stated before C1 we unstable and his ba stated staff guided (bathroom. In regard)	9/24/20, at 10:35 a.m. family ted C1 was very impulsive elt the agency was working M-A stated staff now had a gait g and stated they had talked				

STATI AND F	EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		TE SURVEY
		24G382	B. WING	100	00	C 9/30/2020
ł	E OF PROVIDER OR SUPPLIER NGLE CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP CO 5624 73RD AVE NO BROOKLYN PARK, MN 55429		9/30/2020
PR	FIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
W	belt was being use the premises. LSI-/interventions were staff to document p. A review of the kios "When ambulatory possible obstacles balance and suppo 2017-2018. On 9/24/20, at 1:36 (PM)-A stated C1 w. PM-A stated one m. fallen and gone to t. days later. PM-A stated to de PM-A stated C1 had was checked on every PM-A stated when to wherever he went. On 9/24/20, at 2:22 stated C1 had many hospitalized on 9/13 hospitalization, C1 w. therapy. RN-A state for C1 had been dor stated she felt he hamobility. RN-A verific comprehensively as she had not been avenutil a week prior to to the Incident/Accided did not read them arme," they go to the coprofessional (QIDP).	o fast. LSI-A stated a transfer d only when C1 was outside A further stated fall located on the kiosk (used for progress notes). Sk indicated, monitor for falling, monitor for steady gait and and in tricky terrain, provide rt." The tasks were dated p.m. the program manager ras not stable and he "trips." orning he came in and C1 had the hospital and returned two ated after hospitalization, the oral a camera in his room and ery two hours while in bed. C1 was up staff followed him p.m. registered nurse (RN)-A or falls recently and was assessed by physical did the last facility assessment the in December of 2019 and and a definite decrease in	W 3	131		

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		24G382	B. WING		0.9	C /30/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 331	there had been a la communication at the communication at the Parket of	ack of staff and a lack of he agency. I p.m. the QIDP stated the re filled out by staff and he discussed them with RN-A. To one had completed a sessment of C1's falls. The C1 was awake a transfer belt used but had not been use staff had not been properly it. Interview on 9/24/20, at 9:35 stated the agency had not a aware C1 had so many falls. It is discussed they usually received notices clients were falling and stated any notes in the clinic records cy had notified them of C1's elated to client falls was ecceived.	W 3:			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		24G382	B. WING		09/30/2020
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
SHINGLE	E CREEK OPTION			5624 73RD AVE NO	
O, IIIVOL	- OKELK OF HON			BROOKLYN PARK, MN 55429	!
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLÉTION
W 336	Continued From pa	ge 14	W 336	W336	
	changes in health c	are status. In addition failed to			·
		sical was completed by the		The RN will conduct quarterly review	
	physician for 1 of 3	clients (C1).		of client health status and report ti	ne
	Findings include:			findings of those reviews to the QI	DP
	i mangs morade.			upon completion. The QIDP will be	
	C1's Health Care Pl	lan 2020, identified diagnosis	•	responsible for ensuring the review	vs are
		n, Mental Retardation,		completed on a quarterly basis. Th	e , ,
		Bruxism, The Health Care		initial quarterly health status review	e ws /1/12/202
		s to include medical, dental,		will be completed by 11/12/20 and	l l
		aviors and medication use. reviewed by registered nurse		every 90 days thereafter.	
		20. The signature lines for April		every 30 days increation.	
		ere blank. The Physical Health			
	portion of the Health	n Care Plan indicated C1's last			
		completed 8/6/19, and was			1
		urther review of the medical			
		nce of a physical exam sician since 8/6/19. The			
		dicated a physical therapy			
		en completed August 2019,			
	but did not address	C1's falls since 2019.			
	Dente to the state of	0/00/00			
		9/29/20, at 2:23 p.m. RN-A for his annual physical but			
		19 they agency had held off			1
		1 had been out of the facility			
		nts. RN-A stated she was			
	unsure if C1 had see	en his physician since last			
		ne quarterly review, RN-A			
		signed off on the completion			
ļ	knows" what's going	riews because she "just			
	MINOWS WITHERS GOING	, OII.			
			;		
1					1 1

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		01430	B. WING			0/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHINGLE	CREEK OPTION	5624 73Ri BROOKLY	D AVE NO YN PARK, MI	N 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
5 000	144.56 and/or Minn 144.653, this correct pursuant to a surve found that the deficit herein are not corrected shall with a schedule of the Minnesota Department of the number and MN Ruindicated below. We several items, failuritems will be considered the confidence of multi-part ruassessment of a firm violated during the corrected. You may request a that may result from	hether a violation has been compliance with all rule provided at the tagule number or MN Statute then a rule or statute contains to to comply with any of the lered lack of compliance.	5 000			
	the Department with notice of assessment on 9/23/20 - 9/30/2 was conducted. The	thin 15 days of receipt of a ent for non-compliance. O, a complaint investigation e following complaint(s) was ntiated: HG382004C.				
		n compliance with nnesota Rules, Chapter 4665 upervised Living Facilities				
5 825	MN Statute 626.55	7 Subd. 4. VA Reporting.	5 825			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S624 73RD AVE NO BROOKLYN PARK, MN 55429 CAN JOB PREERIX SUMMARY STATEMENT OF DEFICIENCIES ID PREERIX (EACH OFFICENCY MUST BE PRECEDED BY FULL TAG CANSACHE ACTION SHOULD BE CANSACHE PREVAILED BY TAG S 825 Continued From page 1	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
SHINGLE CREEK OPTION S624 T3RD AVE NO BROOKLYN PARK, MN 55429 (EACH DEPOSITION VISITE PERFECED BY PELL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the incident, and any other information that the reporter her lime, date, and location of the incident, and any other information that the reporter preporter may disclose not public data, as defined in section 13.02, and medical records under section 14.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review the agency failed to notify the state agency (SA) of client to client buse for 3 of 3 clients (C2,C4,C5) reviewed for abuse. Finding include: C2's Health Care Plan 2020, identified a history of aggressive behaviors. C2's Intensive Support Services Assessment (ISSA) dated September 2019 - September 2020, identified behaviors affecting her ability to self manage including a history of throwing bowels, plates, phones and books/magazines. A review of C2's Accident and Incident Reports			04.420			1	
SHINGLE CREEK OPTION S624 73RD AVE NO BROOKLYN PARK, MN 55429	NAME OF I	DROVIDED OR SUDDILIED				09/3	0/2020
SUMMARY STATEMENT OF DEFICIENCIES DEFICE NEW PROVIDER'S PLAN OF CORRECTION (CEACH DORRECTIVE ACTION) SHOULD BE (CEACH DORRECTIVE ACTION) SHOULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)					TATE, ZIF GODE		
FREFIX TAG REGULATORY OR LSC (DENTIFYING INFORMATION) 5 825 Continued From page 1 A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, any evidence of the reporter, the time, date, and location of the incident, and any other information that the reporter the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review the agency failed to notify the state agency (SA) of client to to client abuse for 3 of 3 clients (C2,C4,C5) reviewed for abuse. Finding include: C2's Health Care Plan 2020, identified a history of aggressive behaviors. C2's Intensive Support Services Assessment (ISSA) dated September 2019 - September 2020, identified behaviors affecting her ability to self manage including a history of throwing bowels, plates, phones and books/magazines. A review of C2's Accident and Incident Reports	SHINGLE	E CREEK OPTION	BROOKLY	'N PARK, MI	N 55429		
A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, any evidence of previous maltreatment, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review the agency failed to notify the state agency (SA) of client to to client abuse for 3 of 3 clients (C2,C4,C5) reviewed for abuse. Finding include: C2's Health Care Plan 2020, identified a history of aggressive behaviors. C2's Intensive Support Services Assessment (ISSA) dated September 2019 - September 2020, identified behaviors affecting her ability to self manage including a history of throwing bowels, plates, phones and books/magazines. A review of C2's Accident and Incident Reports	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
dated 6/2020-9/2020 identified the following:	5 825	A mandated reported oral report to the contelecommunications similar device shall. The common entry reports. To the extension be of sufficient content adult, the caregiver suspected maltreath previous maltreatm the reporter, the timincident, and any of reporter believes must the suspected maltreath reporter may disclosin section 13.02, and section 144.335, to comply with this sufficient to the client above. This MN Requirement by: Based on interview agency failed to not client to to client above. Finding include: C2's Health Care Paggressive behavioned Services Assessment 2019 - September 22 affecting her ability history of throwing books/magazines. A review of C2's Active states and services are services and services	er shall immediately make an ammon entry point. Use of a sedevice for the deaf or other be considered an oral report. Point may not require written int possible, the report must tent to identify the vulnerable, the nature and extent of the ment, any evidence of ent, the name and address of the date, and location of the ider information that the light be helpful in investigating reatment. A mandated se not public data, as defined and medical records under the extent necessary to odivision. The state agency (SA) of use for 3 of 3 clients and for abuse. Itan 2020, identified a history of rest (ISSA) dated September 2020, identified behaviors to self manage including a powels, plates, phones and cident and Incident Reports	5 825			

Minnesota Department of Health

STATE FORM 6899 VXJR11 If continuation sheet 2 of 5

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		01430	B. WING		09/3	0/2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHINGLE	E CREEK OPTION		D AVE NO YN PARK, MI	N 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
5 825	Continued From pa	ge 2	5 825			
	measures included	to a cabinet. Preventative , keep a closer eye on C2 one staff in the apartment.				
	chair. Another Clier window. C2 stood u chair. C5 moved be from C2. Preventa	n anxious and was sitting in a at (C5) was looking out the up and pushed C5 into an arm whind the chair to get away tive measures included, keep er when she is in an anxious				
	and C2 pushed C4 and walked away.	ng in a chair, C4 walked by with one hand. C4 stumbled Preventative measures ose eye on C2 when peers				
	bathroom. Another pushed the client.	out of her room to use the client walked by and C2 Preventative measures irect C2 while creating a shield ked by.				
	C2 pushed him with Preventative measu	alking around the apartment. In two hands into the counter. In ures included, keep a close Idistance from other individuals				
	C5. Preventative m	red near C2 and C2 pushed neasures included, continue to where res are in relation to C2.				
	walked in front of he hands in the chest. included, stay close	s walking to her chair, C5 er. C2 pushed C5 with two Preventative measures e to aggressing clients so they her in the apartment.				

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Minnesota Department of Health STATE FORM

VXJR11 If continuation sheet 3 of 5

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` '	SURVEY PLETED
		01430	B. WING			C 30/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	·	
SHINGL	E CREEK OPTION		D AVE NO YN PARK, MI	N 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
5 825	7/30/20, C2 was be When walking to he client into the table. included, staff must chair. 8/9/20, C2 was dire had an ATO (aggree who was seated ne 9/16/20, C2 pushed shoulder causing cl Preventative measured closer and get betwoe 9/20/20, C2 charge into the wall with twoe During interview on 2:00 p.m. program sometimes C2 had and there was a lot would aggress againstated for the most stated if C2 was abher to sit down and stated other times of two handed pushed PM-B stated she was fallen as a result of there had not been On 9/24/20, at 2:51 disability profession "temporary interrup got aggressive. The themselves between directed her to sit in	ing directed to her chair. er chair C2 pushed another Preventative measures walk with C2 all the way to cted to stay in her seat and ssion toward others) on C4 xt to her. I another client on the right ient to fall to the floor. ures included, shadow C2 ween her and other peers. Id toward C4 and pushed him	5 825			

Minnesota Department of Health

STATE FORM 6899 VXJR11 If continuation sheet 4 of 5

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		01430	B. WING			C 30/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHINGL	E CREEK OPTION	5624 73RI BROOKLY	D AVE NO YN PARK, MI	N 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
5 825	On 9/25/20, at 1:44 incidents of aggress clients had not beer QIDP stated a repo there was an injury The QIDP stated if report was needed. A facility policy titled Prevention Plan, Intundated, indicated	p.m. the QIDP stated the sion between C2 and other reported to the SA. The rt was not required unless as a result of an altercation. there was no injury, then no discounty and Vulnerable Adults Abuse ternal Reporting System werbal or physical aggression as not constitute abuse unless	5 825			

Minnesota Department of Health

STATE FORM 6899 VXJR11 If continuation sheet 5 of 5

PRINTED: 10/20/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		24G382	B. WING			C / 30/2020
	PROVIDER OR SUPPLIER E CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP C 5624 73RD AVE NO BROOKLYN PARK, MN 55429		100/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	rs	W 0	00		
W 149	On 9/23/20 - 9/30/2 conducted to invest The complaint was were cited at W331 In addition, the Con care services servic compliance with 42 An full survey was of STAFF TREATMEN CFR(s): 483.420(d) The facility must de policies and proced mistreatment, negle This STANDARD is Based on interview facility failed to developrevention policy w immediately report clients (C2) reviewe aggressive behavior Findings include: A facility policy titled Prevention Plan, In-	20, an abbreviated survey was tigate complaint HG382004C. substantiated and deficiencies, W336, W149, W153 addition of Participation- health ces was found not to be in CFR 483.460. Conducted 9/29/20 - 9/30/20. NT OF CLIENTS (1) Evelop and implement written lures that prohibit ect or abuse of the client. Is not met as evidenced by: and document review, the elop a facility abuse hich directed staff to client to client abuse for 1 of 3 ed who displayed physically	W 1			
		es not constitute abuse unless				
		cident and Incident Reports 20 identified the following:				
L ABORATOR'	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIRE	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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	CON	TE SURVEY MPLETED C
		24G382	B. WING			/30/2020
	PROVIDER OR SUPPLIER CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE	OULD BE	(X5) COMPLETION DATE
W 149	-6/25/20, C1 charg shoved the client in measures included when there is only -7/8/20, C2 had be chair. Another clier window. C2 stood a chair. C5 moved be from C2. Preventa others away from haffect. -7/9/20, C2 was sitt and C2 pushed C4 and walked away. included, keep so were around. -7/12/20, C2 came bathroom. Another pushed the client. included, try to record for anyone who wa -7/13/20, C4 was wow C2 pushed him with Preventative meas eye on C2 and her in the apartment. -7/15/20, C5 wande C5. Preventative meas eye on C2 and her in the apartment.	ed at another client (C4) and nto a cabinet. Preventative II, keep a closer eye on C2 one staff in the apartment. en anxious and was sitting in a nt (C5) was looking out the up and pushed C5 into an arm with ending the chair to get away tive measures included, keep ner when she is in an anxious ting in a chair, C4 walked by with one hand. C4 stumbled Preventative measures lose eye on C2 when peers out of her room to use the client walked by and C2 Preventative measures lirect C2 while creating a shield	W 149			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		E CONSTRUCTION	COMPLETED		
		24G382	B. WING	i			C / 30/2020
	PROVIDER OR SUPPLIER E CREEK OPTION			5	TREET ADDRESS, CITY, STATE, ZIP CODE 624 73RD AVE NO ROOKLYN PARK, MN 55429	1 00.	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
W 149	-7/30/20, C2 was b When walking to he client into the table included, staff muschair. -8/9/20, C2 was dirhad an ATO (aggrewho was seated newho was seated newhowas ne	eing directed to her chair. er chair C2 pushed another. Preventative measures t walk with C2 all the way to ected to stay in her seat and ssion toward others) on C4 ext to her. ed another client on the right lient to fall to the floor. ures included, shadow C2 ween her and other peers. ed toward C4 and pushed him to hands. 19/24/20, at approximately manager (PM)-B stated aggression when it was loud agging on. PM-B stated C2 we against staff or other clients most part it was pretty mild. was about to "charge," staff down and usually that worked er times C2 would be e or two handed pushed or leone. PM-B stated she was ints had fallen as a result of at stated there had not been		149			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G382	B. WING			C 09/30/2020	
	PROVIDER OR SUPPLIER E CREEK OPTION			5624	EET ADDRESS, CITY, STATE, ZIP CODE 4 73RD AVE NO OOKLYN PARK, MN 55429	,	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 149	directed her to sit in C2 did not sit in her barricade her.	n C2 and other clients and her chair. The QIDP stated if chair staff would basically	W 1	49			
W 153	incidents of aggress clients had not been QIDP stated the aggreport incidents of of the SA unless some	p.m. the QIDP stated the sion between C2 and other n reported to the SA. The ency was not required to client to client altercations to eone was injured. The QIDP no injury, then no report was	W 4	5 2			
VV 153	CFR(s): 483.420(d) The facility must en mistreatment, negle injuries of unknown immediately to the state of t	exp(2) Issure that all allegations of ect or abuse, as well as source, are reported administrator or to other noce with State law through	W 1	53			
	Based on interview agency failed to not	s not met as evidenced by: and document review the tify the state agency (SA) of use for 3 of 3 clients and for abuse.					
	Finding include:						
	aggressive behavior Services Assessment 2019 - September 2 affecting her ability	lan 2020, identified a history of ors. C2's Intensive Support ent (ISSA) dated September 2020, identified behaviors to self manage including a bowels, plates, phones and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		24G382	B. WING		09	/30/2020	
	PROVIDER OR SUPPLIER CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP 5624 73RD AVE NO BROOKLYN PARK, MN 55429			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 153	books/magazines. A review of C2's Addated 6/2020-9/202 6/25/20, C1 charge shoved the client in measures included when there is only 7/8/20, C2 had been chair. Another Clien window. C2 stood in chair. C5 moved be from C2. Preventa others away from haffect. 7/9/20, C2 was sittle and C2 pushed C4 and walked away, included, keep so were around. 7/12/20, C2 came obathroom. Another pushed the client, included, try to record for anyone who was 7/13/20, C4 was with C2 pushed him with Preventative mease eye on C2 and her in the apartment. 7/15/20, C5 wander C5. Preventative mease con C5. P	ccident and Incident Reports 20 identified the following: ed at another client (C4) and a cabinet. Preventative 1, keep a closer eye on C2 one staff in the apartment. en anxious and was sitting in a ant (C5) was looking out the up and pushed C5 into an arm enind the chair to get away tive measures included, keep ner when she is in an anxious ing in a chair, C4 walked by with one hand. C4 stumbled Preventative measures lose eye on C2 when peers out of her room to use the client walked by and C2 Preventative measures lirect C2 while creating a shield	W 15	3			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED	
		24G382	B. WING _			C / 30/2020	
	PROVIDER OR SUPPLIER CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP OF 5624 73RD AVE NO BROOKLYN PARK, MN 55429	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 153	7/18/20, As C2 was walked in front of h hands in the chest. included, stay close don't reach each of 7/30/20, C2 was be When walking to he client into the table included, staff must chair. 8/9/20, C2 was dire had an ATO (aggre who was seated new houlder causing control of the wall with two preventative measured closer and get betwoeld of the wall with two preventations of the wall with two prevent	s walking to her chair, C5 er. C2 pushed C5 with two Preventative measures e to aggressing clients so they her in the apartment. Fing directed to her chair. For chair C2 pushed another Preventative measures et walk with C2 all the way to Forced to stay in her seat and ession toward others) on C4 ext to her. If another client on the right lient to fall to the floor. Force and other peers. If another dient on the right lient to fall to the floor. Force and other peers. If another client on the right lient to fall to the floor. Force and other peers. If another client on the right lient to fall to the floor. Force and other peers. If another client on the right lient to fall to the floor. Force and other peers.	W 15	3			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	CON	(X3) DATE SURVEY COMPLETED	
		24G382	B. WING _			C / 30/2020	
	PROVIDER OR SUPPLIER CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP COD 5624 73RD AVE NO BROOKLYN PARK, MN 55429			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 153	On 9/24/20, at 2:51 disability professior "temporary interrup got aggressive. The themselves betwee directed her to sit in C2 did not sit in her barricade her. On 9/25/20, at 1:44 incidents of aggres clients had not bee QIDP stated a report here was an injury The QIDP stated if report was needed. A facility policy titled Prevention Plan, In undated, indicated between clients doe the behavior cause HEALTH CARE SE CFR(s): 483.460	p.m. the qualified intellectual pal (QIDP) stated "C2 had a tion procedure" for when she e QIDP stated staff put en C2 and other clients and her chair. The QIDP stated if chair staff would basically p.m. the QIDP stated the sion between C2 and other n reported to the SA. The ent was not required unless as a result of an altercation. There was no injury, then no de Vulnerable Adults Abuse ternal Reporting System verbal or physical aggression es not constitute abuse unless as serious harm.	W 15				
	Based on observative review, the Condition 483.460, health car agency failed to ensure and implementation	is not met as evidenced by: tion, interview and document on of Participation at 42 CFR re services was not met. The sure thorough assessment n of interventions to reduce s for 1 of 1 clients (C1)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	24G382		B. WING		C 09/30/2020		
	PROVIDER OR SUPPLIER E CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO BROOKLYN PARK, MN 55429			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			((EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 318	Continued From pa	ge 7	W 3	18			
W 331	implement practices 1 of 1 clients (C1) r NURSING SERVIC CFR(s): 483.460(c) The facility must pre	ES	W 3	31			
	Based on observat review, the agency comprehensive ass develop and implen	s not met as evidenced by: tion, interview and document failed to complete a tessment of falls and failed to nent interventions to reduce lls for 1 of 1 clients (C1) ple falls.					
	(ISSA) dated 9/10/1 coordination along placed him at risk if indicated C1 had a 8/21/19, at which tir recommended to cowhen walking long. The physical therapusing a tub instead ISSA directed staff	ontrol speed and offer support distances or in the community. by assessment also indicated of shower for bathing. The to monitor for falls. ncident Reports dated 6/22/20					
		C1 experienced a total of 25					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		24G382	B. WING _			/30/2020
	PROVIDER OR SUPPLIER E CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 331	missed the chair ar included, monitor C -6/30/20, C1 was stand slipped to his boon the arm rest of t measures included morning when using -7/10/20, C1 walked heard a thump and bottom. Preventative monitor C1 when go -7/12/20, C1 stood started walking, loss bottom. C1 hit his breck on the wall. Poshadowing C1 close apartment7/17/20, Staff were hammock and C1 local control of the ground here preventative measures staff when putting C -7/21/20, C1 was were control of the control of	ttempting to sit at the table, and fell. Preventative measures at closely for imbalance. Itanding up from the commode tottom. C1 scraped his elbow he commode. Preventative, monitor C1's gait in early grommode. It into his room for a nap. Staff found him on the floor on his re measures included, closely being into his room alone. It is balance and fell on his reack, shoulder blades and reventative measures included ely when moving in the reaction at the post his balance. Staff lowered blding his gait belt. It is attempting to put C1 in the cost his balance. Staff lowered blding his gait belt. It is attempting to put C1 in the cost his balance. Staff lowered blding his gait belt. It is attempting to put C1 in the cost his balance. Staff lowered blding his gait belt. It is attempting to put C1 in the cost his balance. Staff lowered blding his gait belt. It is attempting to put C1 in the cost his balance. Staff lowered blding his gait belt. It is attempting to put C1 in the cost his balance. Staff lowered blding his gait belt. It is a staff lowered blding his gait belt. It is a staff lowered blding his gait belt. It is a staff lowered blding his gait belt.	W 33	,		
	-7/30/20, C1 stood his bottom. Prevent shadow C1 closely	Staff lowered him to the floor. up from a chair and fell onto cative measures included, when standing up from chairs. following C1 to the kitchen				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
	24G382	B. WING		09	/30/2020	
NAME OF PROVIDER OR SUPPLIER SHINGLE CREEK OPTION		1	STREET ADDRESS, CITY, STATE, ZIP CO 5624 73RD AVE NO BROOKLYN PARK, MN 55429			
PREFIX (EACH DEFICIENCY N	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			SHOULD BE	(X5) COMPLETION DATE	
and lost his balance second time when stup. -8/13/20, C1 fell atterchair. Preventative muse of black shoes in -8/19/20, C1's motion entered his room and floor was wet so staff Preventative measur mat "or something" to there was an inapproduction of the second of the	and fell. C1 then fell a aff were trying to assist him aff were trying to assist him appring to sit on a kitchen neasures included, consider natead of brown shoes. In sensor sounded and staff of found C1 on the floor. C1's flassumed he slipped. The sincluded, C1 may need a color provide more grip when opriate urination. From a chair, C1's shoe pped forward and landed on ive measures included,	W 331				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	COMPLETED		
		24G382	B. WING _			30/2020
	PROVIDER OR SUPPLIER E CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
W 331	Preventative measiclosely. 9/3/20, C1's motion found sitting on the measures included woke up on the overall content and fell and a Preventative measiclosely when moving a closely clo	a sensor sounded and he was floor in urine. Preventative, closely monitor C1 when he emight shift. Abulating, bumped into another and bumped his head. Ares included, shadow C1 ag around. Alking with staff from the and fell. Are bathroom with staff, Arming out of the shower. Are included, dry floor of the fall. Preventative, make sure he was seated Arought to the hospital on affafter staff noticed a swollen sion during the morning. Areved heavy redness around a suspected he had fallen and object. Preventative measures of check for injury thoroughly,	W 33			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C	
		24G382	B. WING _		09	/30/2020	
	PROVIDER OR SUPPLIER CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP C 5624 73RD AVE NO BROOKLYN PARK, MN 55429			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 331	thump and found he measures included his room. Review of C1's Hodated 9/15/20 indiciblind and had experimental of falls in the last 2 indicated C1 had be and evaluation and with recommendat staff to monitor and times. During observation skills instructor (LS bathroom. LSI-A lebriefly, then returned C1 ambulated back was wearing a town Wet foot prints were leading out into the C1 ambulated to the During interview or member (FM)-A stand stated he/she with him on that. Fibelt they were using about the belt last your stated before C1 we unstable and his bastated staff guided bathroom. In regard	in his room alone. Staff heard a im on the floor. Preventative I, monitor C1 closely when in spital Discharge Summary, cated C1 had autism, was deaf, crienced an increased number 4 hours. The summary een admitted for observation I was diagnosed with a stroke, ion from physical therapy for d assist with ambulation at all in on 9/24/20, at 9:54 a.m. living Isl)-A escorted C1 to the ft C1 in the bathroom alone ed with a towel. At 10:11 a.m. It to his room with LSI-A. C1 el and did not have shoes on the noted on the bathroom floor a common area. At 10:16 a.m. In el kitchen while LSI-A held is shirt. In 9/24/20, at 10:35 a.m. family ated C1 was very impulsive felt the agency was working M-A stated staff now had a gait g and stated they had talked	W 33	1			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		24G382	B. WING _		ı	/30/2020
	PROVIDER OR SUPPLIER CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	belt was being use the premises. LSI-interventions were staff to document particles and support of the kio "When ambulatory possible obstacles balance and support of the kio" when ambulatory possible obstacles balance and support of the kio" when a stated C1 in particles and gone to days later. PM-A stated one in fallen and gone to days later. PM-A stated C1 has was checked on expense of the professional (QIDF) and the	of fast. LSI-A stated a transfer d only when C1 was outside A further stated fall located on the kiosk (used for progress notes). sk indicated, monitor for falling, monitor for steady gait and and in tricky terrain, provide ort." The tasks were dated 5 p.m. the program manager was not stable and he "trips." norning he came in and C1 had the hospital and returned two tated after hospitalization, the do a one to one staff for C1. In a camera in his room and very two hours while in bed. C1 was up staff followed him 2 p.m. registered nurse (RN)-A my falls recently and was 3/20. RN-A stated following the was assessed by physical led the last facility assessment one in December of 2019 and and a definite decrease in	W 33	1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		l` ′	TE SURVEY MPLETED	
		24G382	B. WING			C 09/30/2020	
	PROVIDER OR SUPPLIER CREEK OPTION			STREET ADDRESS, CITY, STATE, ZIP COD 5624 73RD AVE NO BROOKLYN PARK, MN 55429	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 331	communication at tool of the communication at tool of the computation at the comprehensive assigned as the comprehensive assigned as the could have been using the could not find a could not find a could not find a could have been using the could not find a could have been using the could not find a could	ick of staff and a lack of he agency. I. p.m. the QIDP stated the re filled out by staff and he discussed them with RN-A. To one had completed a sessment of C1's falls. The C1 was awake a transfer belt used but had not been use staff had not been properly it. Interview on 9/24/20, at 9:35 stated the agency had not a aware C1 had so many falls. It is discussed the telephone and stated any notes in the clinic records cy had notified them of C1's elated to client falls was eccived.	w a				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 09/30/2020	
	24G382					
NAME OF PROVIDER OR SUPPLIER SHINGLE CREEK OPTION				STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	IOULD BE COMPLÉTION	
W 336	SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed November 24, 2020

Administrator Shingle Creek Option 5624 73rd Ave No Brooklyn Park, MN 55429

Dear Administrator:

Event ID: VXJR11 - Notice of Termination due to Condition of Participation (CoP) not met

Dear Administrator:

On September 30, 2020, a complaint investigation survey was conducted at your facility by the Minnesota Department 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 investigation, the survey team noted one or more deficiencies and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID):

W318 42 CFR 483.420 Health Care Services

As of November 24, 2020, the Condition of Participation has not been corrected. Therefore, we are recommending to the Minnesota Department of Human Services that your Medicaid agreement to provide services as an Intermediate Care Facility for Individuals with Intellectual Disabilities be terminated. The termination date will be December 29, 2020.

The Minnesota Department of Human Services will notify you of their decision regarding our termination recommendation and your appeal rights.

If you have any quetions on this matter, please contact me.

Any Johour

Amy Johnson, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Telephone: 651-201-4121



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email December 7, 2020

Administrator Shingle Creek Option 5624 73rd Ave No Brooklyn Park, MN 55429

RE: Event ID: VXJR12

Dear Administrator:

On November 24, 2020, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) 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. Based on the PCR complaint investigation, we have determined your facility does meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and standard deficiencies pursuant to the complaint investigation, on September 30, 2020. The Condition of Participation that was corrected is listed below.

W318 42 CFR § 483.420 Health Care Services

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

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

Sincerely,

Any Johour

Amy Johnson, Program Specialist

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Telephone: 651-201-4121 Fax: 651-201-9697

Enclosure

cc: Licensing and Certification File