DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

December 16, 2021

Administrator
REM Heartland Inc Birch
206 Thomas Drive
Mankato, MN 56001

RE: Event ID: HZD411

Dear Administrator:

On November 22, 2021, survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. At the time of the survey, the survey team noted one or more deficiencies.

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

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

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed

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

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

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

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

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

Sincerely,

Kim Tyson

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G429	A. BUILDING _____ B. WING _____	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HEARTLAND INC BIRCH	206 THOMAS DRIVE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On 11/17, 11/18 and 11/22//21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following complaints were found to be UNSUBSTANTIATED with no deficiencies cited. HG429011C (MN71497) The following complaints were found to be SUBSTANTIATED with no deficiencies cited: HG429012C (MN73839) HG429013C (MN77212) HG429009C (MN77215) HG429015C (MN77218) HG429016C (MN77219) HG429014C (MN77217) HG429010C (MN67827) However, as a result of the investigation, deficiencies were cited 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		
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.	W 153		

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

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W 153	Continued From page 1 This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the designated State Agency (SA) for 5 of 5 client's (C3, C4, C5, C6 & C7) reviewed for allegations of neglect. Findings include: Review of a Vulnerable Adult (VA) report dated 9/30/21, at 1:45 p.m. indicated direct support professional (DSP)-A came to the facility to drop off a set of keys on 9/29/21, at around 10:00 p.m. to 10:15 p.m. DSP-A noted there were no staff in the building at the time. DSP-A searched all the client rooms and apartments for DSP-B who was scheduled to work that shift, but could not find that person. DSP-A stayed with the clients (C3, C4, C5, C6 & C7) until 10:30 p.m., when DSP-B entered the building. DSP-B stated she was standing on the side of the building stretching her back, and getting some fresh air. The VA report indicated it was unknown how long the clients were in the building alone. The VA report indicated the incident occurred on 9/29/21, at 10:00 p.m. to 10:15 p.m., and the state agency (SA) was not notified until 9/30/21, at 1:45 p.m. Interview on 11/16/21, at 2:00 p.m. the area director (AD) confirmed the above incident had not been reported to the SA immediately, per facility policy. The facility's policy "Vulnerable Adult" revised 8/20/18, was reviewed. The reporting procedures included; mandated reporters may report suspected instances of abuse, neglect or financial exploitation internally or externally, mandated reporters should report immediately to	W 153		

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W 153	Continued From page 2 the PD or AD or utilize the chain of command, mandated reporters making an initial report remain responsible for seeing that their report reaches the appropriate external agency timely.	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 and document review, the facility failed to thoroughly investigate an allegation of financial exploitation to determine and implement measures to protect 1 of 1 client (C2) financial funds, who was reported to have misappropriation of property. This had the potential to affect all 5 clients currently residing in the facility.. Findings include: Review of the Kardex located in C2's record (undated), included diagnosis of Prader-Willi syndrome (a genetic disorder that causes intellectual disability), verbal apraxia (motor speech disorder that makes it hard to speak) and borderline IQ (categorization of intelligence). Review of the Risk Assessment dated 2/11/21, identified C2 as presenting a risk with managing finances. The assessment indicated C2 was unaware of money limitations and spends money too freely. Staff are to manage C2's finances along with his parents. A money management program is in place to have C2 work on staying within a budget. Review of a vulnerable adult (VA) report	W 154		

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W 154	Continued From page 3 submitted on 6/11/21, at 4:10 p.m. The report indicated C2's case manager (CM)-A, requested C2' financial records for auditing. While auditing C2's financial records, CM-A noted that there was a purchase at Cub foods for a visa gift card on 4/18/21, for $86.95. CM-A indicated the facility staff told her it was for a flower purchase. The report indicated C2 was asked and could not recall purchasing a gift card for that amount. A bank statement also showed another purchase for $150.00 dollars at Cubs foods in 12/20. A purchase for Hy-Vee foods on 12/11/20, included a $20.00 gift card. There was also a purchase from petty cash at Old Navy Clothing for $64.55 and Kohl's for $51.38. The facility was notified on 5/17/21, by CM-A regarding concerns for purchases that were unaccounted for and requested all receipts for purchases in the past 2 years. The requested receipts were not provided by the facility. The VA report further indicated C2's personal needs money is deposited on to a debit card, and could use a debit card instead of a gift card. CM-A indicated she had been verbally told by facility staff that C2 spent the gift cards on Christmas gifts, flowers and subscribing to Netflix. CM-A indicated that she had been told C2 had purchased these items, but were unable to provide any receipts or dates when purchased. The facility staff had not kept a record of receipts for these purchases. There were no ledgers to track purchases. Review of a letter sent to the facility regional director (RD) and area director (AD) on 6/3/21, by CM-A, included concerns related to the accountability of C2's financial funds, and requested financial ledgers and receipts for the past 2 years. CM-A indicated this had been requested on 5/18/21. The petty cash ledgers	W 154		

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W 154	Continued From page 4	W 154		

were received on 5/26/21, but only 2 months had been completed. The letter also requested the facility conduct an investigation related to what happened with C2's unaccounted funds, that were identified during the audit review.

Review of a word document indicated the facility AD interviewed the facility licensed practical nurse (LPN) and the facility supervisor (FS) on 6/4/21. The document identified receipts for the gift card purchases were found, but did not have receipts for what was purchased with the gift cards. The note indicated there were random purchases by gift cards, when interviewing staff. Receipts could not be found to account for the purchases There was no documentation or entries on the financial ledger tracking log.

Review of an e-mail dated 7/1/21, by the facility AD sent to facility management staff, indicated she had done an informal investigation, and that it did not appear that there were any signs of theft. The facility AD indicated C2 would be paid back the amount of funds that the facility did not have receipts, for the month of 12/20. The purchases that had not been accounted for was in the amount of $373.93 dollars.

Review of C2's financial documents from 11/20 to 5/21, did not include any documentation for the purchases listed above. There were receipts for the visa gift cards, but were not logged on the financial ledger. There were no receipts for what the gift cards had been used for.

Review of the Itemized Financial Statement assessment dated 2/11/21, identified C2 as requiring assistance with all financial affairs, including monitoring and management of financial

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W 154	Continued From page 5 accounts. The document indicated the facility is responsible for providing full assistance to the client with personal spending funds. The staff are responsible to assist the client with managing and handling money, including obtaining receipts for all transactions. The statement also indicated approval is needed by the clients power of attorney (POA) when spending over $150 dollars. Review of the progress notes during the time of the purchase on 12/20, for a $150.00 gift card. There was no documentation indicating the POA had been notified for approval of the gift card purchase. Review of the documentation provided by the facility, lacked a thorough investigation had been done, when the AD became aware of the allegations of misappropriation of property on 5/17/21. Although the AD interviewed 2 staff on 6/4/21, and identified the staff had not been keeping purchase receipts or documenting on the financial ledger, there were no interventions to account for tracking financial funds. The AD confirmed direct support professionals (DSP)'s assist C2 with all of his purchases. The AD also verified all facility staff have access to the clients funds, but had not interviewed all staff. Interview on 11/17/21, at 11:30 a.m. CMA-A stated while reviewing C2's financial records on 5/17/21, she had identified discrepancies that included unaccountable purchases. CMA-A indicated she had requested the financial ledger and purchase receipts, but did not receive them. CMA-A indicated she was unsure if the facility was tracking C2's funds appropriately and felt there was a possibility of misappropriation of funds.	W 154		

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W 154	Continued From page 6 Interview on 11/17/21, at 12:40 p.m. family member (FM)-A (guardian) indicated she had not been involved with C2's financial funds FM-A indicated the facility takes care of C2's financial funds. Although, FM-A further stated the facility was suppose to get her permission when making purchases over $100.00. FM-A stated she did not get asked for approval for the $150.00 gift card purchased on 12/20. Interview on 11/17/21, at 1:00 p.m. the facility LPN indicated she had assisted C2 with some of his purchases, that included gift cards. The facility LPN stated she usually keeps receipts, but does not track all of the clients purchases. The facility LPN indicated C2 will often purchase items on-line, and then there is no receipt or tracking. The facility LPN did confirmed C2 required assistance with his financial funds and purchases. The facility LPN further indicated staff should be tracking all purchases, but has not been. Interview on 11/19/21, at 11:00 a.m. the facility AD indicated she had been aware of C2's financial concerns since 5/17/21, but did not investigate until 6/4/21. The facility AD indicated she conducted an informal internal investigation by interviewing the facility LPN and the FS. The facility AD indicated she did not feel there was misappropriation of property, after the interviews. The facility AD stated she was informed C2 had been purchasing on-line and that receipts could not be obtained. The AD indicated the facility had refunded C2's unaccountable funds for purchases, that did not have receipts. Review of the policy "vulnerable Adult" revised on	W 154		

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W 154	Continued From page 7 8/20/18, indicated when the facility has reason to know that an internal or external report of alleged abuse/neglect/maltreatment/financial exploitation has been made, the facility must complete an internal review. Corrective action must be implemented if necessary, to protect the health and safety of VA's. When a report of suspected abuse, neglect or financial exploitation is received, the regional director (RD) or designee shall take steps to ensure that further abuse, neglect or financial exploitation does not occur, to start the investigation within 24 hours of the initial report.	W 154		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 16, 2021

Administrator
REM Heartland Inc Birch
206 Thomas Drive
Mankato, MN 56001

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: HZD411

Dear Administrator:

The above facility was surveyed on November 17, 2021 through November 22, 2021 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

When all orders are corrected, the first page of the order form should be signed and returned to:

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

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Sincerely,

Kim Tyson

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

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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 11/17, 11/18 and 11/22/21,, a complaint investigation was conducted. Your facility was found to be not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaints were found to be SUBSTANTIATED with no licensing orders issued. HG429012C (MN73839) HG429013C (MN77212)	5 000		

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5 000	Continued From page 1 HG429009C (MN77215) HG429015C (MN77218) HG429016C (MN77219) HG429014C (MN77217) HG429010C (MN67827) The following complaints were found to be UNSUBSTANTIATED with no licensing orders issued. HG429011C (MN71497) However, as a result of the investigation, related licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and electronically return to: elizabeth.silkey@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	5 815		

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5 815	Continued From page 2 defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the designated State Agency (SA) for 5 of 5 client's (C3, C4, C5, C6 & C7) reviewed for allegations of neglect. Findings include:	5 815		

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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
5 815	Continued From page 3 Review of a Vulnerable Adult (VA) report dated 9/30/21, at 1:45 p.m. indicated direct support professional (DSP)-A came to the facility to drop off a set of keys on 9/29/21, at around 10:00 p.m. to 10:15 p.m. DSP-A noted there were no staff in the building at the time. DSP-A searched all the client rooms and apartments for DSP-B who was scheduled to work that shift, but could not find that person. DSP-A stayed with the clients (C3, C4, C5, C6 & C7) until 10:30 p.m., when DSP-B entered the building. DSP-B stated she was standing on the side of the building stretching her back, and getting some fresh air. The VA report indicated it was unknown how long the clients were in the building alone. The VA report indicated the incident occurred on 9/29/21, at 10:00 p.m. to 10:15 p.m., and the state agency (SA) was not notified until 9/30/21, at 1:45 p.m. Interview on 11/16/21, at 2:00 p.m. the area director (AD) confirmed the above incident had not been reported to the SA immediately, per facility policy. The facility's policy "Vulnerable Adult" revised 8/20/18, was reviewed. The reporting procedures included; mandated reporters may report suspected instances of abuse, neglect or financial exploitation internally or externally, mandated reporters should report immediately to the PD or AD or utilize the chain of command, mandated reporters making an initial report remain responsible for seeing that their report reaches the appropriate external agency timely.	5 815		

POC Received - 12/22/21
POC Rejected- 12/27/21
POC Resubmitted- 12/28/21
POC Approved- 12/30/21
liz Silkey

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

PRINTED: 12/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G429	A. BUILDING _____ B. WING _____	C 11/22/2021

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W 000	INITIAL COMMENTS On 11/17, 11/18 and 11/22//21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following complaints were found to be UNSUBSTANTIATED with no deficiencies cited. HG429011C (MN71497) The following complaints were found to be SUBSTANTIATED with no deficiencies cited: HG429012C (MN73839) HG429013C (MN77212) HG429009C (MN77215) HG429015C (MN77218) HG429016C (MN77219) HG429014C (MN77217) HG429010C (MN67827) However, as a result of the investigation, deficiencies were cited 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		
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.	W 153		

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

Area Director 12/28/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153	Continued From page 1 This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the designated State Agency (SA) for 5 of 5 client's (C3, C4, C5, C6 & C7) reviewed for allegations of neglect. Findings include: Review of a Vulnerable Adult (VA) report dated 9/30/21, at 1:45 p.m. indicated direct support professional (DSP)-A came to the facility to drop off a set of keys on 9/29/21, at around 10:00 p.m. to 10:15 p.m. DSP-A noted there were no staff in the building at the time. DSP-A searched all the client rooms and apartments for DSP-B who was scheduled to work that shift, but could not find that person. DSP-A stayed with the clients (C3, C4, C5, C6 & C7) until 10:30 p.m., when DSP-B entered the building. DSP-B stated she was standing on the side of the building stretching her back, and getting some fresh air. The VA report indicated it was unknown how long the clients were in the building alone. The VA report indicated the incident occurred on 9/29/21, at 10:00 p.m. to 10:15 p.m., and the state agency (SA) was not notified until 9/30/21, at 1:45 p.m. Interview on 11/16/21, at 2:00 p.m. the area director (AD) confirmed the above incident had not been reported to the SA immediately, per facility policy. The facility's policy "Vulnerable Adult" revised 8/20/18, was reviewed. The reporting procedures included; mandated reporters may report suspected instances of abuse, neglect or financial exploitation internally or externally, mandated reporters should report immediately to	W 153	**W 153** The program will ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. All incidents of potential allegations of abuse/neglect will be reported immediately to the administrator. Including reports for C3, C4, C5, C6 and C7. All staff will be retrained on Policy 12.1 (Administrative Notification of Incidents) and their responsibilities in regards to reporting all potential allegations of abuse/neglect immediately to the administrator and to MDH. The corrections will be implemented by the QIDP and monitored/audited monthly by the QIDP or Area Director to ensure all allegations have been reported timely. Completion Date: 12/28/21	

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W 153	Continued From page 2 the PD or AD or utilize the chain of command, mandated reporters making an initial report remain responsible for seeing that their report reaches the appropriate external agency timely.	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 and document review, the facility failed to thoroughly investigate an allegation of financial exploitation to determine and implement measures to protect 1 of 1 client (C2) financial funds, who was reported to have misappropriation of property. This had the potential to affect all 5 clients currently residing in the facility.. Findings include: Review of the Kardex located in C2's record (undated), included diagnosis of Prader-Willi syndrome (a genetic disorder that causes intellectual disability), verbal apraxia (motor speech disorder that makes it hard to speak) and borderline IQ (categorization of intelligence). Review of the Risk Assessment dated 2/11/21, identified C2 as presenting a risk with managing finances. The assessment indicated C2 was unaware of money limitations and spends money too freely. Staff are to manage C2's finances along with his parents. A money management program is in place to have C2 work on staying within a budget. Review of a vulnerable adult (VA) report	W 154	**W154** The program will ensure that all allegations are thoroughly investigated in accordance with rules and policies. All incidents of potential allegations will be reported immediately and thoroughly investigated. These investigations will begin immediately within 24 hours and findings documented. The allegations regarding C2 will be thoroughly investigated at this time to ensure all steps have been taken to protect the person and monitor their funds ongoing. The AD, QIS and QIDP will be retrained on the requirements to thoroughly investigate all allegations and immediately implement steps to protect the person. The corrections will be implemented by the Regional Director and monitored by the QIS/AD/QIDP ongoing. The QIDP will audit all allegations at least quarterly to ensure that they have been thoroughly investigated. Completion Date: 12/28/21	

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W 154	Continued From page 3 submitted on 6/11/21, at 4:10 p.m. The report indicated C2's case manager (CM)-A, requested C2' financial records for auditing. While auditing C2's financial records, CM-A noted that there was a purchase at Cub foods for a visa gift card on 4/18/21, for $86.95. CM-A indicated the facility staff told her it was for a flower purchase. The report indicated C2 was asked and could not recall purchasing a gift card for that amount. A bank statement also showed another purchase for $150.00 dollars at Cubs foods in 12/20. A purchase for Hy-Vee foods on 12/11/20, included a $20.00 gift card. There was also a purchase from petty cash at Old Navy Clothing for $64.55 and Kohl's for $51.38. The facility was notified on 5/17/21, by CM-A regarding concerns for purchases that were unaccounted for and requested all receipts for purchases in the past 2 years. The requested receipts were not provided by the facility. The VA report further indicated C2's personal needs money is deposited on to a debit card, and could use a debit card instead of a gift card. CM-A indicated she had been verbally told by facility staff that C2 spent the gift cards on Christmas gifts, flowers and subscribing to Netflix. CM-A indicated that she had been told C2 had purchased these items, but were unable to provide any receipts or dates when purchased. The facility staff had not kept a record of receipts for these purchases. There were no ledgers to track purchases. Review of a letter sent to the facility regional director (RD) and area director (AD) on 6/3/21, by CM-A, included concerns related to the accountability of C2's financial funds, and requested financial ledgers and receipts for the past 2 years. CM-A indicated this had been requested on 5/18/21. The petty cash ledgers	W 154		

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W 154	Continued From page 4 were received on 5/26/21, but only 2 months had been completed. The letter also requested the facility conduct an investigation related to what happened with C2's unaccounted funds, that were identified during the audit review. Review of a word document indicated the facility AD interviewed the facility licensed practical nurse (LPN) and the facility supervisor (FS) on 6/4/21. The document identified receipts for the gift card purchases were found, but did not have receipts for what was purchased with the gift cards. The note indicated there were random purchases by gift cards, when interviewing staff. Receipts could not be found to account for the purchases There was no documentation or entries on the financial ledger tracking log. Review of an e-mail dated 7/1/21, by the facility AD sent to facility management staff, indicated she had done an informal investigation, and that it did not appear that there were any signs of theft. The facility AD indicated C2 would be paid back the amount of funds that the facility did not have receipts, for the month of 12/20. The purchases that had not been accounted for was in the amount of $373.93 dollars. Review of C2's financial documents from 11/20 to 5/21, did not include any documentation for the purchases listed above. There were receipts for the visa gift cards, but were not logged on the financial ledger. There were no receipts for what the gift cards had been used for. Review of the Itemized Financial Statement assessment dated 2/11/21, identified C2 as requiring assistance with all financial affairs, including monitoring and management of financial	W 154		

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W 154	Continued From page 5 accounts. The document indicated the facility is responsible for providing full assistance to the client with personal spending funds. The staff are responsible to assist the client with managing and handling money, including obtaining receipts for all transactions. The statement also indicated approval is needed by the clients power of attorney (POA) when spending over $150 dollars. Review of the progress notes during the time of the purchase on 12/20, for a $150.00 gift card. There was no documentation indicating the POA had been notified for approval of the gift card purchase. Review of the documentation provided by the facility, lacked a thorough investigation had been done, when the AD became aware of the allegations of misappropriation of property on 5/17/21. Although the AD interviewed 2 staff on 6/4/21, and identified the staff had not been keeping purchase receipts or documenting on the financial ledger, there were no interventions to account for tracking financial funds. The AD confirmed direct support professionals (DSP)'s assist C2 with all of his purchases. The AD also verified all facility staff have access to the clients funds, but had not interviewed all staff. Interview on 11/17/21, at 11:30 a.m. CMA-A stated while reviewing C2's financial records on 5/17/21, she had identified discrepancies that included unaccountable purchases. CMA-A indicated she had requested the financial ledger and purchase receipts, but did not receive them. CMA-A indicated she was unsure if the facility was tracking C2's funds appropriately and felt there was a possibility of misappropriation of funds.	W 154		

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W 154	Continued From page 6 Interview on 11/17/21, at 12:40 p.m. family member (FM)-A (guardian) indicated she had not been involved with C2's financial funds FM-A indicated the facility takes care of C2's financial funds. Although, FM-A further stated the facility was suppose to get her permission when making purchases over $100.00. FM-A stated she did not get asked for approval for the $150.00 gift card purchased on 12/20. Interview on 11/17/21, at 1:00 p.m. the facility LPN indicated she had assisted C2 with some of his purchases, that included gift cards. The facility LPN stated she usually keeps receipts, but does not track all of the clients purchases. The facility LPN indicated C2 will often purchase items on-line, and then there is no receipt or tracking. The facility LPN did confirmed C2 required assistance with his financial funds and purchases. The facility LPN further indicated staff should be tracking all purchases, but has not been. Interview on 11/19/21, at 11:00 a.m. the facility AD indicated she had been aware of C2's financial concerns since 5/17/21, but did not investigate until 6/4/21. The facility AD indicated she conducted an informal internal investigation by interviewing the facility LPN and the FS. The facility AD indicated she did not feel there was misappropriation of property, after the interviews. The facility AD stated she was informed C2 had been purchasing on-line and that receipts could not be obtained. The AD indicated the facility had refunded C2's unaccountable funds for purchases, that did not have receipts. Review of the policy "vulnerable Adult" revised on	W 154		

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W 154	Continued From page 7 8/20/18, indicated when the facility has reason to know that an internal or external report of alleged abuse/neglect/maltreatment/financial exploitation has been made, the facility must complete an internal review. Corrective action must be implemented if necessary, to protect the health and safety of VA's. When a report of suspected abuse, neglect or financial exploitation is received, the regional director (RD) or designee shall take steps to ensure that further abuse, neglect or financial exploitation does not occur, to start the investigation within 24 hours of the initial report.	W 154		