

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:

Rem Heartland Inc Birch

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: <u>elizabeth.silkey@state.mn.us</u>

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, Health Program Representative Senior Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Kim Typon

Saint Paul, Minnesota 55164-0970

Phone: 651-201-3831

Email: kim.tyson@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING	C	(X3) DATE SURVEY COMPLETED	
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W 000	survey was comples complaint investigate compliance with 42 requirements for In Individuals with Interpretation of Individuals with	and 11/22//21, an abbreviated sted at your facility to conduct a stion. Your facility was not in a CFR Part 483, subpart I, termediate Care Facilities for ellectual Disabilities. It conducts were found to be ED with no deficiencies cited. (1497) It collaints were found to be with no deficiencies cited: (13839) (1212) (1215) (1218) (1219) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (1217) (12	W 0				
LABORATORY	·	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY IPLETED	
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W 153	This STANDARD Based on interview facility failed to immabuse to the design of 5 client's (C3, Callegations of negletic Findings include: Review of a Vulner 9/30/21, at 1:45 p.r. professional (DSP) off a set of keys or to 10:15 p.m. DSP the building at the client rooms and a scheduled to work that person. DSP-/C4, C5, C6 & C7) rentered the building indicated it was unwere in the building indicated it was unwere in the building indicated the incided 10:00 p.m. to 10:18 (SA) was not notifically policy. The facility's policy 8/20/18, was review included; mandate suspected instance financial exploitation facility policy.	is not met as evidenced by: w and document review, the nediately report allegations of nated State Agency (SA) for 5 4, C5, C6 & C7) reviewed for	W 15	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	CON	TE SURVEY MPLETED	
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	mandated reporters remain responsible	ize the chain of command, smaking an initial report for seeing that their report riate external agency timely.	W 15			
	violations are thoror This STANDARD is Based on interview facility failed to thor allegation of financi and implement mea (C2) financial funds misappropriation of	ve evidence that all alleged				
	(undated), included syndrome (a geneti intellectual disability speech disorder tha borderline IQ (catego Review of the Risk	lex located in C2's record diagnosis of Prader-Willi c disorder that causes /), verbal apraxia (motor at makes it hard to speak) and gorization of intelligence). Assessment dated 2/11/21, genting a rick with managing				
	finances. The asserunaware of money too freely. Staff are along with his parer program is in place within a budget.	senting a risk with managing ssment indicated C2 was limitations and spends money to manage C2's finances and share to have C2 work on staying able adult (VA) report				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF I			D. WING			1/22/2021
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KEWI HE	ARTLAND INC BIR	СН		MANKATO, MN 56001		
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W 154	indicated C2's ca C2' financial reco C2's financial reco a purchase at Cu 4/18/21, for \$86.9 staff told her it was report indicated C recall purchasing bank statement a for \$150.00 dollar purchase for Hy-1 a \$20.00 gift card from petty cash a and Kohl's for \$55/17/21, by CM-A purchases that w requested all receyears. The requested all receyears. The requested the card, and could u card. CM-A indic by facility staff that Christmas gifts, fl Netflix. CM-A indicated any receit The facility staff or these purchases track purchases. Review of a letter director (RD) and by CM-A, include accountability of C requested financipast 2 years. CM-	page 3 I/21, at 4:10 p.m. The report se manager (CM)-A, requested rds for auditing. While auditing ords, CM-A noted that there was b foods for a visa gift card on 95. CM-A indicated the facility as for a flower purchase. The C2 was asked and could not a gift card for that amount. A llso showed another purchase is at Cubs foods in 12/20. A lee foods on 12/11/20, included in the facility was notified on a regarding concerns for ere unaccounted for and eights for purchases in the past 2 sted receipts were not provided at C2 spent the gift cards on lowers and subscribing to cated that she had been told C2 lesse items, but were unable to pts or dates when purchased. There were no ledgers to the C2's financial funds, and all ledgers and receipts for the A indicated this had been 8/21. The petty cash ledgers	W 1	54		

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W 154	been completed. T facility conduct an inhappened with C2's were identified during the nurse (LPN) and the 6/4/21. The documing gift card purchases receipts for what we cards. The note incompurchases by gift conductive Receipts could not purchases There we entries on the finant Review of an e-ma AD sent to facility range of the amount of funding the amount of funding the amount of \$373.93. Review of C2's finated by the visa gift cards, financial ledger. The gift cards had be review of the Item.	id/26/21, but only 2 months had the letter also requested the investigation related to what is unaccounted funds, that ing the audit review. Idocument indicated the facility facility licensed practical the facility supervisor (FS) on ent identified receipts for the is were found, but did not have as purchased with the gift dicated there were random ards, when interviewing staff. The found to account for the vas no documentation or incial ledger tracking log. If dated 7/1/21, by the facility management staff, indicated afformal investigation, and that it there were any signs of theft. Cated C2 would be paid back is that the facility did not have onth of 12/20. The purchases accounted for was in the dollars. Incial documents from 11/20 to be any documentation for the cove. There were receipts for but were not logged on the lare were no receipts for what been used for.	W 15	4			
	requiring assistanc	2/11/21, identified C2 as e with all financial affairs, and management of financial					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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W 154	responsible for proclient with personal responsible to assist handling money, in all transactions. The approval is needed attorney (POA) who Review of the programmer of the purchase on 12 There was no document had been notified for purchase. Review of the document facility, lacked a the done, when the AD allegations of misa 5/17/21. Although the 6/4/21, and identified keeping purchase financial ledger, the account for tracking confirmed direct stassist C2 with all overified all facility stands, but had not Interview on 11/17/stated while review 5/17/21, she had in included unaccount indicated she had mand purchase rece CMA-A indicated swas tracking C2's for all facility stands and purchase rece CMA-A indicated swas tracking C2's for all facility stands and purchase rece CMA-A indicated swas tracking C2's for all facility stands and purchase rece CMA-A indicated swas tracking C2's for all facility stands are considered as a formal facility stands are con	age 5 ument indicated the facility is viding full assistance to the I spending funds. The staff are st the client with managing and cluding obtaining receipts for e statement also indicated by the clients power of en spending over \$150 dollars. The statement also indicated by the clients power of en spending over \$150 dollars. The statement also indicated by the clients indicating the POA or approval of the gift card. The propriation provided by the prough investigation had been became aware of the propriation of property on the AD interviewed 2 staff on ed the staff had not been receipts or documenting on the enter were no interventions to grinancial funds. The AD also taff have access to the clients interviewed all staff. 21, at 11:30 a.m. CMA-A ing C2's financial records on lentified discrepancies that table purchases. CMA-A requested the financial ledger ipts, but did not receive them. The was unsure if the facility funds appropriately and felt illity of misappropriation of	W 15	54			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG		COMI	SURVEY PLETED
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W 154	member (FM)-A (gubeen involved with indicated the facility funds. Although, FM was suppose to get purchases over \$10 get asked for appropurchased on 12/20 Interview on 11/17/LPN indicated she his purchases, that LPN stated she use not track all of the CLPN indicated C2 von-line, and then the The facility LPN did assistance with his purchases. The facility LPN did assistance with his purchases. The facility hid assistance with his purchases. The facility and indicated she had be concerns since 5/1 until 6/4/21. The facility AD indicated misappropriation of The facility AD indicated misappropriation of The facility AD state been purchasing or not be obtained. The refunded C2's unapurchases, that did	21, at 12:40 p.m. family lardian) indicated she had not C2's financial funds FM-A takes care of C2's financial M-A further stated the facility her permission when making 20.00. FM-A stated she did not loval for the \$150.00 gift card 10. 21, at 1:00 p.m. the facility had assisted C2 with some of included gift cards. The facility will often purchase items here is no receipt or tracking. It confirmed C2 required financial funds and hillity LPN further indicated staff all purchases, but has not appear aware of C2's financial funds and hillity AD indicated she mal internal investigation by here was property, after the interviews and that receipts could be AD indicated the facility had occountable funds for	W 1	54			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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W 154	8/20/18, indicated v know that an intern abuse/neglect/malt has been made, the internal review. Cor implemented if nec and safety of VA's. abuse, neglect or fi received, the regio shall take steps to a neglect or financial	when the facility has reason to all or external report of alleged reatment/financial exploitation is facility must complete an rective action must be ressary, to protect the health When a report of suspected nancial exploitation is nal director (RD) or designee rensure that further abuse, exploitation does not occur, to on within 24 hours of the initial	W 1	54		



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.

Page 2

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 Typon

Kim Tyson, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-3831

Email: kim.tyson@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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5 000 Initial Comments		5 000				
	In accordance with 144.56 and/or Minr 144.653, this corre pursuant to a surve found that the deficherein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN Rindicated below. W several items, failuitems will be considered from the modern of a findicated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a findicated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a findicated during the corrected. The following comparison was a found to be not in confidence of the following comparison.	thether a violation has been compliance with all erule provided at the tagule number or MN Statute When a rule or statute contains re to comply with any of the dered lack of compliance. The upon re-inspection with any ule will result in the ne even if the item that was initial inspection was The hearing on any assessments in non-compliance with these at a written request is made to thin 15 days of receipt of a cent for non-compliance. In a compliance with requirements are compliance with requirements and for the conducted. Your facility was compliance with requirements and Facilities (SLF). Total statute of the tag with the second of the conducted of the compliance with requirements and Facilities (SLF).				

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

(X6) DATE TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		01537	B. WING		11/2	2/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
REM HE	ARTLAND INC BIRCH		D, MN 56001			
(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)	JLD BE	(X5) COMPLETE DATE
5 000 5 815	HG429009C (MN7) HG429015C (MN7) HG429016C (MN7) HG429014C (MN7) HG429010C (MN6) The following comp UNSUBSTANTIATE issued. HG429011C (MN7) However, as a resulicensing orders we When corrections a date, make a copy electronically return elizabeth.silkey@st	7215) 7218) 7219) 7217) 7827) Daints were found to be ED with no licensing orders 1497) Ilt of the investigation, related are issued. Are completed, please sign and of these orders and a to:	5 000 5 815			
	(a) A mandated rep believe that a vulne been maltreated, or vulnerable adult ha which is not reason immediately report common entry poin vulnerable adult so admitted to a facility required to report s individual that occu unless: (1) the individual was another facility and reason to believe the maltreated in the proof of the position of the proof of the pro	porter who has reason to brable adult is being or has a who has knowledge that a se sustained a physical injury ably explained shall the information to the t. If an individual is a lely because the individual is y, a mandated reporter is not uspected maltreatment of the rred prior to admission, as admitted to the facility from the reporter has ne vulnerable adult was	3 013			

Minnesota Department of Health

STATE FORM 6899 HZD411 If continuation sheet 2 of 4

Minnesota Department of Health

A. BUILDING: COMPLETED COMPLETED C B. WING 11/22/202	
01537 B. WING 1 44/32/200	
11/22/202	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	E OF PROVIDER OR SUPPLIER
REM HEARTLAND INC BIRCH 206 THOMAS DRIVE MANKATO, MN 56001	M HEARTLAND INC BIRC
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTION (ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY) (X4) ID PROVIDER'S PLAN OF CORRECTION (ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)	EFIX (EACH DEFICIENC
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.	defined in section of clause (4). (b) A person not reprovisions of this sections of this section (c) Nothing in this section of the section

6899

Minnesota Department of Health STATE FORM

HZD411 If continuation sheet 3 of 4

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		01537	B. WING		C 11/22/2021	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 11/2	LIZUZ I
REM HE	ARTLAND INC BIRCI		MAS DRIVE D, MN 56001	l		
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
5 815	Review of a Vulnera 9/30/21, at 1:45 p.m professional (DSP) off a set of keys on to 10:15 p.m. DSP-the building at the tolient rooms and as scheduled to work that person. DSP-AC4, C5, C6 & C7) uentered the building standing on the side back, and getting sindicated it was unlike were in the building indicated the incide 10:00 p.m. to 10:15 (SA) was not notified. Interview on 11/16/2 director (AD) confirmot been reported to facility policy. The facility's policy 8/20/18, was review included; mandated reporters the PD or AD or util mandated reporters remain responsible.	able Adult (VA) report dated in. indicated direct support -A came to the facility to drop 9/29/21, at around 10:00 p.m. A noted there were no staff in ime. DSP-A searched all the partments for DSP-B who was that shift, but could not find a stayed with the clients (C3, intil 10:30 p.m., when DSP-B g. DSP-B stated she was e of the building stretching hereome fresh air. The VA report known how long the clients alone. The VA report on 9/29/21, at 5 p.m., and the state agency ed until 9/30/21, at 1:45 p.m. 21, at 2:00 p.m. the area med the above incident had to the SA immediately, per "Vulnerable Adult" revised wed. The reporting procedures direporters may report es of abuse, neglect or in internally or externally, a should report immediately to lize the chain of command, a making an initial report for seeing that their report or internal agency timely.	5 815			

Minnesota Department of Health STATE FORM

POC Received - 12/22/21 POC Rejected- 12/27/21 POC Resubmitted- 12/28/21

PRINTED: 12/16/2021 POC Approved- 12/30/21 FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES	ŀ	POC	Approved- 12/3 الانتهام	•///		MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	J	(X3) DA	TE SURVEY MPLETED
		24G429	B. WING			-	11	C /22/2021
	ROVIDER OR SUPPLIER ARTLAND INC BIRCH	1		206	REET ADDRESS, CITY, STA 5 THOMAS DRIVE NKATO, MN 56001	TE, ZIP COD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLA (EACH CORRECTIVI CROSS-REFERENCEL DEFIC	E ACTION SH	IOULD BE	(XS) COMPLETION DATE
W 000	INITIAL COMMENT	ΓS	W (000				
	survey was comple complaint investiga compliance with 42 requirements for In-	nd 11/22//21, an abbreviated ted at your facility to conduct a tion. Your facility was not in CFR Part 483, subpart I, termediate Care Facilities for ellectual Disabilities.						
		plaints were found to be ED with no deficiencies cited. 1497)						
		7212) 7215) 7218) 7219) 7217)						
		alt of the investigation, ited at W153 and W154.						
W 153	onsite revisit of you	NT OF CLIENTS	W	153				
	mistreatment, negle injuries of unknown immediately to the	asure that all allegations of ect or abuse, as well as a source, are reported administrator or to other nce with State law through						

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

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		E SURVEY IPLETED
		24G429	B. WING			C 22/2021
	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP (206 THOMAS DRIVE MANKATO, MN 56001		22/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
W 153	Based on intervie facility failed to im abuse to the design of 5 client's (C3, Callegations of neg of 5 client of 6 client of 6 client rooms and a scheduled to work that person. DSP-C4, C5, C6 & C7) entered the building standing on the sideack, and getting indicated it was unwere in the building indicated the incident of 10:00 p.m. to 10:1 (SA) was not notif of 11/16 director (AD) confinot been reported facility policy. The facility's policy (S/20/18, was revisincluded; mandate suspected instance financial exploitations)	is not met as evidenced by: w and document review, the mediately report allegations of gnated State Agency (SA) for 5 C4, C5, C6 & C7) reviewed for	W	The program will ensurallegations of mistreat neglect or abuse, as we injuries of unknown so reported immediately administrator or to oth in accordance with Stathrough established proposed All incidents of potentiallegations of abuse/nebe reported immediate administrator. Including for C3, C4, C5, C6 and Call staff will be retrained Policy 12.1 (Administration of Incident their responsibilities in reporting all potential of abuse/neglect immediate administrator and the administrator and The corrections will be implemented by the Quantitored/audited most the QIDP or Area Directions all allegations in reported timely. Completion Date: 12	ment, ell as urce, are to the ner officials te law occedures. al eglect will ely to the ag reports C7. ed on ative ts) and a regards to allegations ediately to to MDH. IDP and onthly by ctor to nave been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		24G429	B. WING			C 22/2021
	PROVIDER OR SUPPLIER ARTLAND INC BIRC			STREET ADDRESS, CITY, STATE, 206 THOMAS DRIVE MANKATO, MN 56001		20.2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
W 154	mandated reporteremain responsible reaches the approximate STAFF TREATME CFR(s): 483.4200. The facility must haviolations are thore This STANDARD Based on intervier facility failed to the allegation of financial function and implement me (C2) financial function potential to affect the facility. Findings include: Review of the Ka (undated), include syndrome (a generated disorder the borderline IQ (cated and the continue I	tilize the chain of command, rs making an initial report le for seeing that their report opriate external agency timely.	Wi	W154	ughly dance with rules idents of will be reported roughly nvestigations ely within 24 ocumented. rding C2 will be ited at this time ive been taken to ad monitor their IDP will be irrements to ite all allegations plement steps to be implemented ector and S/AD/QIDP will audit all uarterly to e been ited.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		24G429	B, WING			11	C /22/2021		
NAME OF PROVIDER OR SUPPLIER REM HEARTLAND INC BIRCH		STREET ADDRESS, CITY, STATE, ZIP CODE 206 THOMAS DRIVE MANKATO, MN 56001				25/2011			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL (SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
W 154	indicated C2's cas C2' financial record C2's financial record a purchase at Cub 4/18/21, for \$86.95 staff told her it was report indicated C2 recall purchasing a bank statement als for \$150.00 dollars purchase for Hy-Va \$20.00 gift card. from petty cash at and Kohl's for \$51 5/17/21, by CM-A1 purchases that we requested all receyears. The requested years. The requested the personal needs me card, and could us card. CM-A indica by facility staff that Christmas gifts, flo Netflix. CM-A indichad purchased the provide any receip The facility staff h for these purchases. Review of a letter director (RD) and by CM-A, included accountability of Crequested financia past 2 years. CM-A	age 3 21, at 4:10 p.m. The report e manager (CM)-A, requested ds for auditing. While auditing rds, CM-A noted that there was foods for a visa gift card on it. CM-A indicated the facility for a flower purchase. The dwas asked and could not digift card for that amount. A so showed another purchase at Cubs foods in 12/20. A dee foods on 12/11/20, included There was also a purchase Old Navy Clothing for \$64.55 38. The facility was notified on regarding concerns for re unaccounted for and dipts for purchases in the past 2 ded receipts were not provided VA report further indicated C2's oney is deposited on to a debit e a debit card instead of a gift ted she had been verbally told ac2 spent the gift cards on overs and subscribing to ated that she had been told C2 see items, but were unable to ts or dates when purchased. and not kept a record of receipts and not kept a record of receipts seent to the facility regional area director (AD) on 6/3/21, d concerns related to the 2's financial funds, and 1 ledgers and receipts for the A indicated this had been 21. The petty cash ledgers	W	.54					

	.ETED
24G429 B. WING C 11/22/	2/2021
NAME OF PROVIDER OR SUPPLIER REM HEARTLAND INC BIRCH STREET ADDRESS, CITY, STATE, ZIP CODE 206 THOMAS DRIVE MANKATO, MN 56001	., 2021
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 \$/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 a fairs,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24G429	B. WING			1	C 22/2021	
NAME OF PROVIDER OR SUPPLIER REM HEARTLAND INC BIRCH			STREET ADDRESS, CITY, STATE, ZIP CODE 206 THOMAS DRIVE MANKATO, MN 56001					
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W 154	responsible for proclient with person responsible to asshandling money, all transactions. Tapproval is needed attorney (POA) we review of the prochase on There was no do had been notified purchase. Review of the do facility, lacked at done, when the Aallegations of mis 5/17/21. Although 6/4/21, and ident keeping purchase financial ledger, taccount for track confirmed direct assist C2 with all verified all facility funds, but had not linterview on 11/1 stated while revies 5/17/21, she had included unaccoundicated she had and purchase rec CMA-A indicated was tracking C2's	cument indicated the facility is roviding full assistance to the al spending funds. The staff are sist the client with managing and including obtaining receipts for The statement also indicated do by the clients power of then spending over \$150 dollars. The system of the spending over \$150 dollars. The statement also indicated do by the clients power of then spending over \$150 dollars. The	W	54				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		24G429	B. WING			1	C /22/2021
	PROVIDER OR SUPPLIE			206	EET ADDRESS, CITY, STATE, ZIP CODE THOMAS DRIVE NKATO, MN 56001	, 117	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
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 online, 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.			.54			
	indicated she had concerns since 5 until 6/4/21. The conducted an infointerviewing the facility AD indicat misappropriation. The facility AD stream purchasing not be obtained. refunded C2's un	9/21, at 11:00 a.m. the facility AD I been aware of C2's financial /17/21, but did not investigate facility AD indicated she formal internal investigation by facility LPN and the FS. The fed she did not feel there was of property, after the interviews, ated she was informed C2 had on-line and that receipts could The AD indicated the facility had naccountable funds for tid not have receipts.					
	Review of the po	licy "vulnerable Adult" revised on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
		24G429	B. WING			ı	C 22/2021	
NAME OF PROVIDER OR SUPPLIER REM HEARTLAND INC BIRCH				STREET ADDRESS, CITY, STATE, ZIP CODE 206 THOMAS DRIVE MANKATO, MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPI	BE	(XS) COMPLETION DATE	
W 154	know that an internabuse/neglect/malt has been made, the internal review. Complemented if necand safety of VA's. abuse, neglect or fireceived, the regionshall take steps to neglect or financial	when the facility has reason to all or external report of alleged reatment/financial exploitation e facility must complete an rective action must be essary, to protect the health When a report of suspected mancial exploitation is mal director (RD) or designee ensure that further abuse, exploitation does not occur, to on within 24 hours of the initial	WI	54				