Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

August 2, 2022

Administrator
Mtai Albert Place
9911 13th Avenue South
Bloomington, MN 55425

RE: Event ID: QOC511

Dear Administrator:

On July 19, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. 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:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Phone: Mobile (651)238-8786

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

Electronically Delivered via email

August 2, 2022

Administrator
Mtai Albert Place
9911 13th Avenue South
Bloomington, MN 55425

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: QOC511

Dear Administrator:

The above facility was surveyed on July 18, 2022 through July 19, 2022 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:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Phone: Mobile (651)238-8786

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 Sarah Grebenc. 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

Mtai Albert Place

Page 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G441	A. BUILDING _____ B. WING _____	C 07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTAI ALBERT PLACE	9911 13TH AVENUE SOUTH BLOOMINGTON, MN 55425

(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 approved by SG - 8/30/22 On 7/18/22 - 7/19/22, 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 complaint was found to be SUBSTANTIATED: HG4413210C (MN85035), with a deficiency cited at W148, W153, and W331. 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 148: Effective immediately and on an ongoing basis guardian and case managers (and if appropriate to the team: other family members) will be notified of any significant incidents, including but not limited to serious illness accident death, abuse or elopement. The Manager that is made aware of an incident (REC coverage, house management, or administrator) will direct the notification of family, guardian, and case manager. The REC coverage, house management, and administrator will receive training on this expectation. The preferred method of communication of the teams will be added to Therap for quick reference. All incidents will be reported to the Guardians, Case managers, (& if appropriate to other family members) within 24 hours, with record of the reporting on the GER (General Event Report). Area Director will monitor GER's to assure timely reporting to team members. Correction date: 9/15/22	
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to notify the legal guardian/family timely of an incident of alleged abuse resulting in an injury for 1 of 2 (C2) clients. Findings include: C2's emergency data form undated, indicated C2 was diagnosed with autism and disability function was moderate.	W 148		

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

Cathy Hanson, RA | Residential Administrator 08/30/22

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 148	Continued From page 1 Facilities General Event Reports (GER) dated 7/8/22, indicated injuries were sustained when C2 took a picture off the wall and slammed it on the ground into two pieces. The paramedics that came with police to the facility spoke to the nurse and staff. They said what had been done would do just fine until morning. This included running his hands under water to rinse and gauze. When interview via phone call on 7/19/22, at 10:29 a.m. family member (FM)-A stated she was not notified of C2's incident that resulted in a hand injury until two days later. FM-A stated C2's grandmother FM-B was informed when dropping off C2 to the facility on 7/10/22 by staff. FM-A stated she was not notified of the incident by management. When interviewed on 7/19/22, at 2:45 p.m. area director (AD) stated the on-call supervisor who was called during the incident would be expected to called the family or guardian of C2. AD stated a change in condition that resulted in an injury would indicate an update to the family or guardian immediately after the incident. On-call supervisor did not return calls to address contacting family/guardian during this incident. Reviewed of C2 records did not indicate family/guardian was notified of incident.	W 148		
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	W 153		

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W 153	Continued From page 2 established procedures. 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 administrator and designated State Agency (SA) for 2 of 2 client (C1 and C2) reviewed for allegations of physical abuse. Findings include: Review of a Vulnerable Adult (VA) reported submitted to the SA on 7/11/22, at 7:25 p.m. with an estimated time and date of this incident was on 7/8/22, 10:00 p.m. indicated C2 was watching TV with three other clients when overnight staff arrived. As evening staff was departing, they told C2 "not to do it again" referring to being awake when overnight would arrive on shift. Overnight staff suggested that the TV be turned off, and C2 went to watch TV in another client's bedroom. As staff led a client to their room the client made a very familiar but disagreeable noise, which triggered a chain reaction. Immediately C2 turned around and said "F ... you!" C2 grabbed things from the wall in the dining room and threw them breaking glass, and then he went after the other client [C1], who sat on the floor. C2 began to hit C1 with an open hand on the side of his head. Overnight staff called for C2 to stop and got closer to divert attention at which point C2 grabbed two laundry baskets and began throwing them at C1. After this, C2 returned to his room and overnight staff called for emergency services (911) to de-escalate the situation as though they were unable to handle it on their own. Before the police were on site C2 opened his bedroom door and began pointing to his hand. Staff waved for him to come out as the doorbell rang and staff opened the door to allow the officers to come in.	W 153	W 153/ (state 5 815) Effective immediately and on an on-going basis, all allegations of mistreatment, neglect, or abuse will be immediately reported to the Administer. **If there is injury, Nursing staff will assure follow to resolution, as well as notification to the primary physician. **The Administrator will assure that State Agency be contacted as required. Direct Service Professionals, site supervisor, and Program Manager will be provided additional training on VA policy, which includes the immediacy of reporting all accusations of suspected abuse or neglect, injuries of unknown origin or any significant medication error to the Administrator and/or to MAARC. This training will include that Client-to-Client aggression with injury/or potential harm would be included in this reporting requirement. REC phone coverage will be included In on this training. The Area Director will monitor for compliance. Completion date: 9/15/22	

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W 153	Continued From page 3 Medics came in to look at the client [C1] who was hit and site nurse was informed of the incident who then spoke to the medics. After this incident, C2 went back to his room and calmed down. When interviewed on 7/18/22, at 3:20 p.m. area director (AD) stated the policy was not followed and the incident had not been reported to the SA immediately. AD stated when allegations of abuse occur the incident was to be reported to the SA immediately and within 2 hours. Facility Vulnerable Adults Maltreatment Reporting and Internal Review Policy dated 8/18, indicated "as a mandated reporter, if you know or suspect that a vulnerable adult has been maltreated or there has been an injury of unknown origin, you must report it immediately".	W 153		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and report to the physician a change in condition for 1 of 2 client (C2) who suffered an injury. Findings include: C2's emergency data form undated, indicated C2 was diagnosed with autism and disability function was moderate. Facilities General Emergency Report (GER) dated 7/8/22, indicated injuries were sustained when C2 took a picture off the wall and slammed	W 331	W 331: Nursing Services Effective immediately and on an on-going basis, all incident of injury or potential injury will be reported immediately to the Nurse (Nurse on call for after hours). **If immediate medical attention Is received, the house LPN will Review the Dr. referral form and complete follow-up as directed. **On the next business day, The LPN will notify clients primary physician of the situation and steps thus far and follow any recommendation, as well as document this communication in a Tlog. ***LPN will monitor and document situation through resolution. Area Director will monitor for compliance by reviewing Tlogs daily and reviewing all GER's for proper notification. Correction date 9/15/22	

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W 331	Continued From page 4 it on the ground into two pieces. The paramedics that came with police to the facility spoke to the nurse and staff. They said what had been done would do just fine until morning. This included running his hands under water to rinse and gauze. When interviewed on 7/19/22, at 10:05 a.m. licensed practical nurse (LPN)-A stated C2's primary physician had not been updated and the physician should had been updated on the next business day after the incident. A facility policy, entitled: Nursing Services Policy dated 9/19/18, indicated the facility must provide clients with nursing services in accordance to their needs: communicate with the client's physician and other healthcare professionals.	W 331		

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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 7/18/22 - 7/19/22, 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 complaint was found to be SUBSTANTIATED: HG4413210C (MN85035) with licensing orders issued at 0380 and 0815. When corrections are completed, please sign and	5 000		

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

Cathy Hanson, RA | Residential Administrator | 8/30/22

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5 000	Continued From page 1 date, make a copy of these orders and electronically return to: Susie.haben@state.mn.us	5 000	W 331: (State 5 380) Nursing Services Effective immediately and on an on-going basis, all incident of injury or potential injury will be reported immediately to the Nurse (Nurse on call for after hours).	
5 380	MN Rule 4665.3300 PURPOSE OF HEALTH SERVICES. Health services shall be utilized to maintain an optimal general level of health and to maximize function, prevent disability, and promote optimal development of each resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and report to the physician a change in condition for 1 of 2 client (C2) who suffered an injury. Findings include: C2's emergency data form undated, indicated C2 was diagnosed with autism and disability function was moderate. Facilities General Event Reports (GER) dated 7/8/22, indicated injuries were sustained when C2 took a picture off the wall and slammed it on the ground into two pieces. The paramedics that came with police to the facility spoke to the nurse and staff. They said what had been done would do just fine until morning. This included running his hands under water to rinse and gauze. When interviewed on 7/19/22, at 10:05 a.m. licensed practical nurse (LPN)-A stated C2 primary physician had not been updated and the	5 380	**If immediate medical attention Is received, the house LPN will Review the Dr. referral form and complete follow-up as directed. **On the next business day, The LPN will notify clients primary physician of the situation and steps thus far and follow any recommendation, as well as document this communication in a Tlog. ***LPN will monitor and document situation through resolution. Area Director will monitor for compliance by reviewing Tlogs daily and reviewing all GER's for proper notification. Correction date 9/15/22	

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5 380	Continued From page 2 physician should had been updated on the next business day after the incident. A facility policy, entitled: Nursing Services Policy dated 9/19/18, indicated the facility must provide clients with nursing services in accordance to their needs: communicate with the client's physician and other healthcare professionals. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 380	W 153/ (state 5 815) Effective immediately and on an on-going basis, all allegations of mistreatment, neglect, or abuse will be immediately reported to the Administer. **If there is injury, Nursing staff will assure follow to resolution, as well as notification to the primary physician. **The Administrator will assure that State Agency be contacted as required.	
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the	5 815	Direct Service Professionals, site supervisor, and Program Manager will be provided additional training on VA policy, which includes the immediacy of reporting all accusations of suspected abuse or neglect, injuries of unknown origin or any significant medication error to the Administrator and/or to MAARC. This training will include that Client-to-Client aggression with injury/or potential harm would be included in this reporting requirement. REC phone coverage will be included In on this training. The Area Director will monitor for compliance. Completion date: 9/15/22	

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5 815	Continued From page 3 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 administrator and designated State Agency (SA) for 2 of 2 client (C1 and C2) reviewed for allegations of physical abuse. Findings include: Review of a Vulnerable Adult (VA) reported submitted to the SA on 7/11/22, at 7:25 p.m. with an estimated time and date of this incident was on 7/8/22, 10:00 p.m. indicated C2 was watching TV with three other clients when overnight staff arrived. As evening staff was departing, they told C2 "not to do it again" referring to being awake	5 815		

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MTAI ALBERT PLACE	9911 13TH AVENUE SOUTH BLOOMINGTON, MN 55425

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5 815	Continued From page 4 when overnight would arrive on shift. Overnight staff suggested that the TV be turned off, and C2 went to watch TV in another client's bedroom. As staff led a client to their room the client made a very familiar but disagreeable noise, which triggered a chain reaction. Immediately C2 turned around and said "F ... you!" C2 grabbed things from the wall in the dining room and threw them breaking glass, and then he went after the other client [C1], who sat on the floor. C2 began to hit C1 with an open hand on the side of his head. Overnight staff called for C2 to stop and got closer to divert attention at which point C2 grabbed two laundry baskets and began throwing them at C1. After this, C2 returned to his room and overnight staff called for emergency services (911) to de-escalate the situation as though they were unable to handle it on their own. Before the police were on site C2 opened his bedroom door and began pointing to his hand. Staff waved for him to come out as the doorbell rang and staff opened the door to allow the officers to come in. Medics came in to look at the client [C1] who was hit and site nurse was informed of the incident who then spoke to the medics. After this incident, C2 went back to his room and calmed down. When interviewed on 7/18/22, at 3:20 p.m. area director (AD) stated the policy was not followed and the incident had not been reported to the SA immediately. AD stated when allegations of abuse occur the incident was to be reported to the SA immediately and within 2 hours. Facility Vulnerable Adults Maltreatment Reporting and Internal Review Policy dated 8/18, indicated "as a mandated reporter, if you know or suspect that a vulnerable adult has been maltreated or there has been an injury of unknown origin, you must report it immediately".	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01565	A. BUILDING: _____ B. WING _____	C 07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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5 815	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 815		