

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email on May 19, 2021

Administrator Mtai Trillium 306 Westgate Drive, Po Box 246 Winsted, MN 55395

RE: Event ID: XOUR11

Dear Administrator:

On May 4, 2021, 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. This survey found one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the survey we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the electronically delivered "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy effective May 3, 2021.

One or more of these deficiencies do not meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID):

W122 42 CFR § 483.420 Client Protections

Federal certification deficiencies are delineated on the enclosed form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC).

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

- 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 correctionk will be completed.

Mtai Trillium May 19, 2021 Page 2

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 B 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 Office: (651) 201-3792

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

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by **June 28, 2021**, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

Sincerely,

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed on May 19, 2021

Administrator Mtai Trillium 306 Westgate Drive, Po Box 246 Winsted, MN 55395

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: XOUR11

Dear Administrator:

The above facility was surveyed on April 29, 2021 through May 4, 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.

Mtai Trillium

Page 2

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

Sarah Grebenc, Unit Supervisor Metro B 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 Office: (651) 201-3792

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.

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

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

Sincerely,

Kim Troom

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 Trillium

Page 3

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-0391
1	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´´	IPLE CONSTRUCTION) CON	TE SURVEY MPLETED
		24G467	B. WING _			C / 04/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MTAI TR	ILLIUM			306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
W 000	was conducted 5/3/ the Minnesota Dep compliance with En regulations §483.47 compliance. INITIAL COMMENT	sed Infection Control survey /21 to 5/4/21, at your facility by artment of Health to determine nergency Preparedness 75. The facility was in full TS h 5/4/21, an abbreviated	W OC)0		
	survey was comple complaint investiga compliance with 42 requirements for In	ted at your facility to conduct a tion. Your facility was NOT IN CFR Part 483, subpart I, termediate Care Facilities for ellectual Disabilities.				
		2340) was substantiated with at W122 and W127.				
	42 CFR 483.420 wa	articipation: Client Protection as found not met. vestigations W149, W153 was				
	An Immediate Jeop W127 on 4/30/21, a	pardy (IJ) was identified at at 4:25 p.m.				
	support professiona placed his hands in house where C1 sle placed his hands on him up. On 4/27/27 DSP-A put his hand his hands around C at C1 to threaten C abuse C1. DSP-A	nuary 2021, when direct al (DSP)-A went outside and the snow and came into the ept in his wheelchair and n C1's back and neck to wake 1, the following was observed: ds in the freezer and cupped C1's neck; DSP-A raised his fist 1 to get up; DSP-A verbally was also verbally abusive to ns in February 2021 and March				

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

TITLE

(X6) DATE

PRINTED: 05/19/2021

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.

		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G467	B. WING				C 04/2021
NAME OF I	PROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MTAI TR	ILLIUM				306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395		
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W 000	2021. DSP-A threa DSP-C not to repor The facility was info 4:25 p.m. The imm on 5/3/21, at 4:15 p the alleged staff on education was prov report when staff to were alleged or occ A full survey was co of 42 CFR 483. Sub Facilities for Individ Disabled (ICF/IID) of facility was found N CLIENT PROTECT CFR(s): 483.420 The facility must en protections requirer This CONDITION if Based on interview Condition of Particip Client Protection, w to protect facility clie abuse by direct sup 2 of 3 clients (C1 an Findings include: See W127 for additf failed to protect 2 o physical/verbal abu (swearing at clients	tened and bulled DSP-B and t these incidents of abuse. ormed of the IJ on 4/30/21, at nediate jeopardy was removed o.m. when the facility placed administrative leave and rided to staff on protocols to client altercations and abuse curred. onducted for the requirements opart I, for Intermediate Care uals who are Intellectually on 5/3/21 and 5/4/21. The OT to be in compliance. TONS	W (

If continuation sheet Page 2 of 17

		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
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MTAI TRI	LLIUM				6 WESTGATE DRIVE, PO BOX 246 INSTED, MN 55395		
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W 122	hands) In addition, threatened by allege incidents unreporter facility administration facility policy. This jeopardy (IJ) to the clients who resided PROTECTION OF CFR(s): 483.420(a) The facility must en Therefore, the facility not subjected to phy psychological abuse This STANDARD is Based on interview facility failed to prot from physical/verbat (swearing at clients purposefully walking hands) In addition, threatened by allege incidents unreporter vulnerable to ongoin This resulted in an health and safety of the home. The IJ began on 1/2 professional (DSP)- and placed his hand house where C1 sle placed his cold han wake him up. The residential administ	the staff were bullied and ed perpetrator (AP) which left d to the state agency or the on as required by law and resulted in an immediate health and safety of all 6 in the home. CLIENTS RIGHTS (5) sure the rights of all clients. ity must ensure that clients are ysical, verbal, sexual or	W 1:				

Facility ID: 01614

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MTAI TR	ILLIUM				06 WESTGATE DRIVE, PO BOX 246 VINSTED, MN 55395		
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W 127	was removed on 5/ facility placed the a leave and education protocols of reportin altercations/abuse. Findings include: C1's Identification F 4/30/21, indicated h disability, had diffice could follow one to In addition his IFS i independently with with a single handle Prevention Plan (IA C1 could be abused than himself and ha potentially dangeron with verbally/physic was unlikely to repor persons. Staff will n situation. In addition able to report, howe remember all the de staff were mandate suspected physical appropriate people. C2's IFS dated 5/3/ profound intellectua and had generalize further indicated sh transfers and indep dated 11/04/20, indi identify potentially overbal/physical abu	3/21, at 4:15 p.m. when the lleged staff on administrative in was provided to staff on ing staff to client Face Sheet (IFS) dated be had moderate intellectual ulty to express himself and two step verbal commands. indicated he fed himself a fork and spoon and drank ed mug. C1's Individual Abuse PP) dated 2/01/21, indicated d by others bigger/stronger ad inability to identify us situations, inability to deal ally aggressive persons and ort abuse to appropriate remove C1 from an unsafe in the IAPP indicated he was ever he may not fully etails of a situation, Trillium d reporters and will report any abuse on [C1]'s behalf to the 21, indicated she had al disabilities, was legally blind d anxiety disorder. The IFS e was assist of one with endent to walk. C2's IAPP icated she had inability to langerous situations and se. In addition C2's IAPP a not be able to report or	W 1	27			

If continuation sheet Page 4 of 17

		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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W 127	Continued From pa	ige 4	W	127			
	4/27/21, at 12:45 p. knocked at front do time and got no ans and heard care give a FUCKER and "YO YOU NEED TO EA C1 at the counter w ate. The group hon the witnessed verba During an interview supervisor (HS) sta incident that occurre supervisor and was was afraid of DSP-/ said. The hospice r and called the nurse incident.	to int Intake Form dated .m. indicated a hospice nurse for on 4/27/21, around lunch swer. They entered the home er (DSP-A) say to (C1)"You are DU ARE PISSING ME OFF, T". Hospice nurse observed with DSP-A next to him while he me nurse was made aware of al abuse by the hospice nurse. 4/30/21, at 9:45 a.m. house the d she was informed of the ed on 4/27/21, by her informed the hospice nurse A after she overheard what he nurse finished her visit, left e at the house to report the an an a					
	DSP-B stated he we on the day shift. DS irritated that day. D he got up C1, who we entered the room and said, "you better get these". C1 shunner DSP-B stated he to to say that to him?" walked away. DSP at lunch time, he ob in the freezer and the neck and C1 was uf head no and shrund stated in January 20 his hands in the sno	r on 4/30/21, at 10:23 a.m. orked with DSP-A on 4/27/21, SP-B stated DSP-A was DSP-B stated that morning as was assist of 2, DSP-A nd put up his fist up to C1 and at up or your gonna get one of d away from DSP-A's fist. Ind DSP-A, "Why did you have and DSP-A glared at him and P-B then stated later that day, pserved DSP-A put his hands hen cup his hands around C1's upset by this and shook his k away from DSP-A. DSP-B 021, he observed DSP-A put ow and come in the house and 1's neck and shoulders to					

If continuation sheet Page 5 of 17

		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
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W 127	wake him up while I happy, and shook a at DSP-B and laugh another incident in observed DSP-A put front of him and sait make his bed. C1 v and shook his head stated he was afrait because DSP-A tolk would happened to report but felt bullie did not report the in During an interview company's internal completed an interr abuse reports. Thr investigation of the found there were of staff were bullied by incidents. They sho informed managem to the state agency. During an interview DSP-C stated she c abuse C2 twice. DS assist of one but co DSP-C stated the fi February 2021 while "get the fuck up" an March 2021 when D "you fucking little bi either one of the ince "Oh just go tell your then stated her fam felt she tried to dea	he was in his w/c, C1 was not and whimpered. DSP-A looked ned. DSP-B stated there was March 2021, where he unch C1's teddy bear right in id this was how to get C1 to was upset and said "No! No!" and made his bed. DSP-B d to report these incident d DSP-B if he reported, things him. DSP-B knew he should d and threatened by DSP-A so incidents. Ton 4/30/21, at 12:52 p.m. the investigator stated the facility hal investigation of the alleged ough the course of the verbal abuse on 4/27/21, they ther incidents by DSP-A but y DSP-A and did not report build have immediately nent so a report could be made	W 1	127			

Facility ID: 01614

If continuation sheet Page 6 of 17

		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /			(X3) DATE SURVE COMPLETED	
		24G467	B. WING				C 04/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MTAI TR	ILLIUM				06 WESTGATE DRIVE, PO BOX 246 VINSTED, MN 55395		
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W 127	the ability to make a During interview 4/3 stated when he ass was on his cell pho call and he was ove DSP-A stated he ra he normally did not because his car was he has never verbat the clients. A Vulnerable Adults Internal Review Pol it is the policy of Ma served by this prog vulnerable to maltre reporting of suspect The immediate jeop was removed on 5/ could be verified by review the facility has perpetrator on adm was provided to sta shift, updated their who to report abuse altercations occurre All staff were interv other allegations of any other staff. Sta Vulnerable Adult Ma Internal Review Pol and state requirement the home were eva harm. The above in 5/3/21, from 12:00 which included DSF	a report to the SA directly. 30/21, at 2:11 p.m. DSP-A sisted C1 to eat on 4/27/21, he ne with an important phone erheard by the hospice nurse. rely swore and he said words say to the collision center s being fixed. DSP-A stated Ily or physically abused any of Maltreatment Reporting and icy reviewed 8/2018, indicated ary T. Inc. to protect the adults ram who are considered eatment and to require the	W	127			

If continuation sheet Page 7 of 17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		24G467	B. WING _		05/0		
	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE 306 WESTGATE DRIVE, PO BOX 246			
MTAI TR	ILLIUM			WINSTED, MN 55395			
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W 127	Continued From pa	ige 7	W 12	27			
W 149			W 14	9			
polici	policies and proced	evelop and implement written lures that prohibit ect or abuse of the client.					
	Based on interview facility failed to imp procedures consist that direct staff to in to client abuse to S	s not met as evidenced by: v and document review, the lement abuse policies and ent with federal regulations mmediately report alleged staff tate Agency (SA) for 2 of 3 who was verbally and by staff.					
	Findings include:						
	4/27/21, at 12:45 p. knocked at front do time and got no ans heard care giver [D FUCKER and "YOU YOU NEED TO EA C1 at the counter w ate. The group hor	oint Intake Form dated .m. indicated a hospice nurse for on 4/27/21, around lunch swer, entered the home and SP-A] say to [C1] "You are a J ARE PISSING ME OFF, T". Hospice nurse observed with DSP-A next to him while he me nurse was made aware of al abuse by the hospice nurse.					
	supervisor (HS) sta incident that occurr supervisor and was was afraid of DSP- said. The hospice	4/30/21, at 9:45 a.m. house ated she was informed of the ed on 4/27/21, by her informed the hospice nurse A after she overheard what he nurse finished her visit, left e at the house. The HS					

If continuation sheet Page 8 of 17

		AND HUMAN SERVICES			FORM	: 05/19/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
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W 149	Continued From pa	ige 8	W 14	49		
		that day so she did not make a agency and was unsure who				
	DSP-B stated he we on the day shift. DS irritated that day. D he got up C1, who we entered the room a said, "you better ge these". C1 shunner DSP-B stated he to to say that to him?" walked away. DSP at lunch time, he ob in the freezer and th neck and C1 was u head no and shrink stated in January 20 his hands in the sno put his hands on C7 wake him up while happy, and shook a at DSP-B and laugh another incident in observed DSP-A put front of him and sait make his bed. C1 was stated he was afrait DSP-A told DSP-B	y on 4/30/21, at 10:23 a.m. orked with DSP-A on 4/27/21, SP-B stated DSP-A was DSP-B stated that morning as was assist of 2, DSP-A and put up his fist up to C1 and et up or your gonna get one of d away from DSP-A's fist. And DSP-A, "Why did you have and DSP-A glared at him and P-B then stated later that day, oserved DSP-A put his hands hen cup his hands around C1's upset by this and shook his sing away from DSP-A. DSP-B 021, he observed DSP-A put ow and come in the house and 1's neck and shoulders to he was in his w/c, C1 was not and whimpered. DSP-A looked hed. DSP-B stated there was March 2021, where he unch C1's teddy bear right in id this was how you got C1 to was upset and said "No! No!" d and made his bed. DSP-B d to report things because if he reported, things would DSP-B felt bullied and -A.				
	company's internal completed the facili	on 4/30/21, at 12:52 p.m. the investigator stated he ity investigations of incidents ough the course of the				

Facility ID: 01614

If continuation sheet Page 9 of 17

		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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MTAI TR	ILLIUM				06 WESTGATE DRIVE, PO BOX 246 VINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
W 149	found out there were who were bullied by incidents and shoul management so a r state agency. During an interview DSP-C stated she c abuse C2 twice. DS assist of one but co DSP-C stated the fi February 2021 while "get the fuck up" an March 2021 when D "you fucking little bi either one of the inc "Oh just go tell your then stated her mot tried to deal with it c stop. She stated sh to make a report to During an interview licensed practical n informed by the hos DSP-A and C1 on 4 receive the calls ab make a report to the know she needed to During interview 5/3 administrator stated been reported to the by the facility. A Vulnerable Adults Internal Review Pol	verbal abuse on 4/27/21, he re other incidents and staff / DSP-A and did not report d have immediately informed report could be made to the report could be made to the said of the second one was in DSP-C overheard DSP-A said, report could not report cidents because DSP-A said, report was the HS and felt she on her own and told DSP-A to ne was unaware of the ability the SA directly. ron 5/3/21, at 10:00 a.m. urse (LPN)-A stated she was spice nurse of the incident with 4/27/21, and usually did not out any incidents and did not e state agency and did not e state agency and did not o. 3/21, at 12:00 p.m. residential d these incidents should have e stated agency immediately a Maltreatment Reporting and licy reviewed 8/2018, indicated		149			
	Internal Review Pol						

If continuation sheet Page 10 of 17

		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		24G467	B. WING				C 04/2021
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
MTAI TR	ILLIUM				06 WESTGATE DRIVE, PO BOX 246 /INSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149 W 153	served by this progr vulnerable to maltre reporting of suspec the report indicated	ram who are considered eatment and to require the ted maltreatment. In addition you must report immediately.	W 1 W 1				
	mistreatment, negle injuries of unknown immediately to the a	sure that all allegations of ect or abuse, as well as source, are reported administrator or to other nce with State law through					
	Based on interview facility failed to imm abuse to the design	s not met as evidenced by: and document review, the nediately report allegations of nated State Agency (SA) for 2 I C2) reviewed for allegations					
	Findings include:						
	4/30/21, indicated h disability, had difficu could follow one to In addition his IFS in independently with with a single handle Prevention Plan (IA C1 could be abused than himself and ha potentially dangerou with verbally/physic	Face Sheet (IFS) dated he had moderate intellectual ulty to express himself and two step verbal commands. ndicated he fed himself a fork and spoon and drank ed mug. C1's Individual Abuse .PP) dated 2/01/21, indicated d by others bigger/stronger ad inability to identify us situations, inability to deal ally aggressive persons and ort abuse to appropriate					

If continuation sheet Page 11 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		24G467	B. WING				C 04/2021
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MTAI TR	ILLIUM				06 WESTGATE DRIVE, PO BOX 246 VINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 153	Continued From pa	ge 11	W	153			
	profound intellectua and had generalized further indicated sh transfers and indep dated 11/04/20, indi identify potentially of verbal/physical abui indicated she would defend herself from A Common Entry P 4/27/21, at 12:45 p. knocked at front do time and got no ansi heard care giver [D FUCKER and "YOU YOU NEED TO EA C1 at the counter w ate. The group hor the witnessed verba During an interview supervisor (HS) stati incident that occurr supervisor and was was afraid of DSP-/ said. The hospice for and called the nurses stated she was off to report to the state at made the report. During an interview DSP-B stated he wo on the day shift. Da irritated that day. D	21, indicated she had I disabilities, was legally blind d anxiety disorder. The IFS e was assist of one with endent to walk. C2's IAPP icated she had inability to langerous situations and se. In addition C2's IAPP I not be able to report or maltreatment. oint Intake Form dated m. indicated a hospice nurse or on 4/27/21, around lunch swer, entered the home and SP-A] say to [C1] "You are a JARE PISSING ME OFF, T". Hospice nurse observed ith DSP-A next to him while he ne nurse was made aware of al abuse by the hospice nurse. 4/30/21, at 9:45 a.m. house ted she was informed of the ed on 4/27/21, by her informed the hospice nurse A after she overheard what he nurse finished her visit, left e at the house. The HS hat day so she did not make a igency and was unsure who on 4/30/21, at 10:23 a.m. orked with DSP-A on 4/27/21, SP-B stated DSP-A was SP-B stated that morning as was assist of 2, DSP-A					

If continuation sheet Page 12 of 17

		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY IPLETED
		24G467	B. WING	i			C 04/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MTAI TR	ILLIUM				806 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 153	entered the room a said, "you better ge these". C1 shunner DSP-B stated he to to say that to him?" walked away. DSP at lunch time, he ob in the freezer and th neck and C1 was u head no and shrink stated in January 20 his hands in the sno put his hands on C7 wake him up while happy, and shook a at DSP-B and laugh another incident in observed DSP-A put front of him and sait make his bed. C1 was and shook his head stated he was afrait DSP-A told DSP-B happened to him. If threatened by DSP- During an interview company's internal completed the facilit that occurred. Threat investigation of the found out there wer who were bullied by incidents and shoul management so a n state agency.	nd put up his fist up to C1 and t up or your gonna get one of d away from DSP-A's fist. Id DSP-A, "Why did you have and DSP-A glared at him and P-B then stated later that day, oserved DSP-A put his hands hen cup his hands around C1's pset by this and shook his ing away from DSP-A. DSP-B 021, he observed DSP-A put ow and come in the house and 1's neck and shoulders to he was in his w/c, C1 was not and whimpered. DSP-A looked ned. DSP-B stated there was March 2021, where he unch C1's teddy bear right in id this was how you got C1 to was upset and said "No! No!" d and made his bed. DSP-B d to report things because if he reported, things would DSP-B felt bullied and	W 1	153			

If continuation sheet Page 13 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/19/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	Сом	E SURVEY PLETED
		24G467	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MTAI TR	ILLIUM			306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 153	abuse C2 twice. DS assist of one but co DSP-C stated the fi February 2021 while "get the fuck up" an March 2021 when D "you fucking little bi either one of the ind "Oh just go tell your then stated her mod tried to deal with it of stop. She stated sh to make a report to During an interview licensed practical n informed by the hos DSP-A and C1 on 4 receive the calls ab make a report to the know she needed to During an interview residential administ should have been r immediately by the A Vulnerable Adults Internal Review Pol it was the policy of adults served by thi considered vulneral require the reporting In addition the repo- immediately.	SP-C stated C2 was blind and ould hear and understand. rst incident occurred in e DSP-A got C2 up he said id the second one was in DSP-C overheard DSP-A say, tch". DSP-C did not report cidents because DSP-A said, mommy about this". DSP-C ther was the HS and felt she on her own and told DSP-A to be was unaware of the ability the SA directly. on 5/3/21, at 10:00 a.m. urse (LPN)-A stated she was spice nurse of the incident with 4/27/21, and usually did not out any incidents and did not e state agency and did not e state agency and did not on 5/3/21, at 12:00 p.m. rator stated these incidents eported to the stated agency facility. Maltreatment Reporting and icy reviewed 8/2018, indicated Mary T. Inc to protect the s program who are ble to maltreatment and to g of suspected maltreatment. rt indicated you must report	W 153			

If continuation sheet Page 14 of 17

		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		24G467	B. WING				C 04/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
MTAI TR	ILLIUM				06 WESTGATE DRIVE, PO BOX 246 /INSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 369	The system for drug that all drugs, includ self-administered, a This STANDARD is Based on observat review, the facility fivere administered (GT) to prevent pot accordance to acce for 2 of 6 clients (C medication administ Findings include: C6's Identification F indicated she had p and was fed throug anything by mouth During observation 5/4/2021, at 8:11 a. (DSP)-D was obser medications. DSP- (antiseizure medica millimeters (ml) into then poured into a I contained a cup of to pour 4 ml Lasix beneprotein (protein cup of water and m then entered C6's r into G-tube by grav together mixed in 1 followed 125 ml of w	g administration must assure ding those that are are administered without error. s not met as evidenced by: tion, interview and document ailed to ensure medications separately via gastric tube ential adverse interactions in eptable professional standards 6 and C4) reviewed for stration. Face Sheet dated 4/3/2021, profound intellectual disability h a G-tube and did not take due to aspiration risk. of medication pass on m., direct support professional rved to set up C6's D opened a bottle of tegretol ation) and poured 10 o a clear medication cup, and Pyrex measuring cup that water. DSP-D then proceeded (diuretic) and 1 scoop of n powder) and poured into the ixed them all together. DSP-D oom. Flushed 125 ml of water ity flow, then gave medications cup of water by gravity and	W 3	369			

If continuation sheet Page 15 of 17

		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		24G467	B. WING				C 04/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
MTAI TR	ILLIUM				06 WESTGATE DRIVE, PO BOX 246 VINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 369	Continued From par instructed her it was medications together C4's Identification F indicated she was p and was gastric tub C4's current signed 10/05/2020, indicate one tablet daily, pre- capsule daily, leveti mI daily, Zyprexa (a ondansetron (prever During interview 5/4 manager (PM) state G-tubes and receive through the G-tube further stated she w LPN-A the procedur During interview 5/4 Geritom pharmacy he was not aware th together. Pharm-C of practice to give m time due to the pote During interview 5/4 stated she was una be given all together stomach.	age 15 s "ok to give all of the er". Face Sheet dated 4/30/2021, profound intellectual disabled be fed due to failure to thrive. I physician orders dated ed she received fiber laxative evacid 30 milligram (mg) iracetam (anticonvulsant) 15 antipsychotic) 7.5 mg daily, ent nausea) 4 mg daily. 4/2021, at 9:00 a.m. program ed C6 and C4 both have ed all of their medications and all at once. The PM vas instructed by the facility re was to give them together. 4/2021, at , at 9:21 a.m. consultant (Pharm)-C stated he staff gave the medications then stated it was a standard nedications by G-tube one at a ential for an adverse reaction. 4/2021, at 10:15 a.m. LPN-A aware medications should not er since they all go into the	W 3		DEFICIENCY)		
	Care undated, indic "Check with the pha that the pills may be same time. Also ch	Gastrostomy Tube Feeding cated Giving the Medication armacists or nurse to be sure e crushed and given at the neck with pharmacy to see if der content can be opened and					

If continuation sheet Page 16 of 17

		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		24G467	B. WING) 04/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MTAI TR	ILLIUM				06 WESTGATE DRIVE, PO BOX 246 VINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 369	Continued From pa dissolved."	age 16	W 3	369			
	with the pharmacis	/ procedure indicated to check t or nurse to give medications DSP-D gave medications					

Facility ID: 01614

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		01614	B. WING			C 05/04/2021	
					05/04	4/2021	
	PROVIDER OR SUPPLIER			STATE, ZIP CODE 'E, PO BOX 246			
MTAI TR	ILLIUM		D, MN 55395	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE	
5 000	Initial Comments		5 000				
	144.56 and/or Minn 144.653, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of fit the Minnesota Depart Determination of wit corrected requires of requirements of the number and MN Ru indicated below. We several items, failure items will be conside Lack of compliance item of multi-part ru assessment of a fir violated during the corrected. You may request a that may result from orders provided that the Department wit notice of assessment On 4/29/21 through Department visited following correction corrections are com	hether a violation has been compliance with all e rule provided at the tag ule number or MN Statute /hen a rule or statute contains re to comply with any of the lered lack of compliance. e upon re-inspection with any ule will result in the ne even if the item that was initial inspection was hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance. h 5/4/21, surveyor of this the above provider and the norder was issued. When mpleted, please sign and date, se orders and return the hent of Health Division		In accordance with Minnesota Sta section 144.56 and/or Minnesota section 144.653, this correction o been issued pursuant to a survey reinspection, it is found that the d or deficiencies cited herein are no corrected, a fine for each violation corrected shall be assessed in accordance with a schedule of fir promulgated by rule of the Minne Department of Health.	Statute, rrder has 7. If, upon eficiency ot n not		

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

TITLE

(X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		LETED
		01614	B. WING	C 05/04/2021		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MTAI TR	ILLIUM		GATE DRIV , MN 55395	/E, PO BOX 246		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
5 000	Continued From pa	ge 1	5 000			
	Suite 220 Attention: Sarah Gr St Paul MN 55164 or email Sarah Gre sarah.grebenc@sta	benc at		Determination of whether a vic been corrected requires comp all requirements of the rule pro- tag number and MN Rule num Statute indicated below. Whet statute contains several items, comply with any of the items w considered lack of compliance compliance upon re-inspection item of multi-part rule will resu assessment of a fine even if th was violated during the initial in was corrected. You may request a hearing on assessments that may result f non-compliance with these orce provided that a written request the Department within 15 days of a notice of assessment for non-compliance.	liance with ovided at the ber or MN n a rule or failure to vill be . Lack of n with any it in the he item that nspection any rom lers is made to	
5 815	(a) A mandated rep believe that a vulne been maltreated, or vulnerable adult has which is not reason immediately report common entry poin vulnerable adult sol admitted to a facility required to report s individual that occu unless:	7 Subd. 3. VA Timing of report. orter who has reason to rable adult is being or has r who has knowledge that a s 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	5 815			

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED C
		01614	B. WING			04/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MTAI TR	RILLIUM		STGATE DRIVE D, MN 55395	E, PO BOX 246		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
5 815		-	5 815			
	maltreated in the pr (2) the reporter known that the individual is defined in section 6 clause (4). (b) A person not recompositions of this se- report as described (c) Nothing in this se- report as described (c) Nothing in this se- report has been man (d) Nothing in this se- report has been man (d) Nothing in this se- reporter from also re- agency. (e) A mandated rep- reason to believe the 626.5572, subdivisi (5), occurred must subdivision. If the re- believes that an inv- will determine or sh- reported error was criteria under section paragraph (c), clause may provide to the to the lead agency is event meets the cri subdivision 17, para- lead agency shall c making an initial dis- subdivision 9c. This MN Requiremen- by: Based on interview facility failed to imm- abuse to the design	ws or has reason to believe a vulnerable adult as 26.5572, subdivision 21, quired to report under the action may voluntarily				

STATEMEN	D <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		01614	B. WING			C 04/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
				E, PO BOX 246		
MTAI TR	ILLIUM		, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
5 815	Continued From pa	ige 3	5 815			
	of abuse.					
	Findings include:					
	4/30/21, indicated h disability, had diffice could follow one to In addition his IFS i independently with with a single handle Prevention Plan (IA C1 could be abused than himself and ha potentially dangeror with verbally/physic	Face Sheet (IFS) dated ne had moderate intellectual ulty to express himself and two step verbal commands. ndicated he fed himself a fork and spoon and drank ed mug. C1's Individual Abuse .PP) dated 2/01/21, indicated d by others bigger/stronger ad inability to identify us situations, inability to deal cally aggressive persons and ort abuse to appropriate				
	profound intellectua and had generalize further indicated sh transfers and indep dated 11/04/20, ind identify potentially overbal/physical abu	21, indicated she had al disabilities, was legally blind d anxiety disorder. The IFS e was assist of one with bendent to walk. C2's IAPP icated she had inability to dangerous situations and se. In addition C2's IAPP d not be able to report or maltreatment.				
	4/27/21, at 12:45 p. knocked at front do time and got no ans heard care giver [D FUCKER and "YOU YOU NEED TO EA C1 at the counter w ate. The group hor	oint Intake Form dated m. indicated a hospice nurse or on 4/27/21, around lunch swer, entered the home and SP-A] say to [C1] "You are a J ARE PISSING ME OFF, T". Hospice nurse observed <i>i</i> th DSP-A next to him while he ne nurse was made aware of al abuse by the hospice nurse.				

PRINTED: 05/19/2021 FORM APPROVED

ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUITIPLE	CONSTRUCTION	(X3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		-		С	
	01614	B. WING		05/04/2021	
PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, ST	ATE, ZIP CODE		
ILLIUM			, PO BOX 246		
		D, MN 55395			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
Continued From pa	ge 4	5 815			
supervisor (HS) sta incident that occurr supervisor and was was afraid of DSP-/ said. The hospice and called the nurs stated she was off t	ted she was informed of the ed on 4/27/21, by her informed the hospice nurse A after she overheard what he nurse finished her visit, left e at the house. The HS that day so she did not make a				
DSP-B stated he we on the day shift. DS irritated that day. D he got up C1, who we entered the room a said, "you better ge these". C1 shunne DSP-B stated he to to say that to him?" walked away. DSP at lunch time, he ob in the freezer and th neck and C1 was u head no and shrink stated in January 20 his hands in the sno put his hands on C ² wake him up while happy, and shook a at DSP-B and laugh another incident in	orked with DSP-A on 4/27/21, SP-B stated DSP-A was DSP-B stated that morning as was assist of 2, DSP-A nd put up his fist up to C1 and t up or your gonna get one of d away from DSP-A's fist. Id DSP-A, "Why did you have and DSP-A glared at him and -B then stated later that day, oserved DSP-A put his hands nen cup his hands around C1's pset by this and shook his ing away from DSP-A. DSP-B 021, he observed DSP-A put ow and come in the house and 1's neck and shoulders to he was in his w/c, C1 was not and whimpered. DSP-A looked ned. DSP-B stated there was March 2021, where he				
	OF CORRECTION PROVIDER OR SUPPLIER ILLIUM SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa During an interview supervisor (HS) sta incident that occurr supervisor and was was afraid of DSP-, said. The hospice f and called the nurs stated she was off f report to the state a made the report. During an interview DSP-B stated he was on the day shift. DS irritated that day. D he got up C1, who y entered the room a said, "you better ge these". C1 shunne DSP-B stated he to to say that to him?" walked away. DSP at lunch time, he ob in the freezer and th neck and C1 was u head no and shrink stated in January 2 his hands in the sno put his hands on C wake him up while happy, and shook a at DSP-B and lauge another incident in	OF CORRECTION IDENTIFICATION NUMBER: 01614 01614 PROVIDER OR SUPPLIER STREET AT 306 WES WINSTEIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed of the incident that occurred on 4/27/21, by her supervisor and was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house. The HS stated she was off that day so she did not make a report to the state agency and was unsure who made the report. During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated that morning as he got up C1, who was assist of 2, DSP-A entered the room and put up his fist up to C1 and said, "you better get up or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated he told DSP-A, "Why did you have to say that to him?" and DSP-A glared at him and walked away. DSP-B then stated later that day, at lunch time, he observed DSP-A put his hands in the freezer and then cup his hands around C1's neck and C1 was upset by this and shook his head no and shrinking away from DSP-A. DSP-B stated in January 2021, he observed DSP-A put his hands in the snow and come in the house and put his hands on C1's neck and shoulders to wake him up while he was in his w/c, C1 was not	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 01614 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed of the incident that occurred on 4/27/21, by her supervisor and was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house. The HS stated she was off that day so she did not make a report to the state agency and was unsure who made the report. During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated DSP-A was irritated the told DSP-A, "Why did you have to say that to him?" and DSP-A glared at him and walked away. DSP-B then stated later that day, at lunch time, he observed DSP-A, Why did you have to say that to him?" and DSP-A glared at him and walked away. DSP-B then stated later that day, at lunch time, he observed DSP-A, but his hands in the snow and come in the house and put his hands on C1's neck and shoulders to wake him up while he was in his w/c, C1 was not happy, and shook and whimpered. DSP-A looked at DSP-B and laughed. DSP-B stated there was another incident in March 2021, where he	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 01614 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 Continued From page 4 During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house. The HS stated she was off that day so she did not make a report to the state agency and was unsure who made the report. During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated DSP-A was irritated that day. DSP-B stated DSP-A was intritated that day. DSP-B stated Inter ming as he got up C1, who was assist of 2, DSP-A entered the room and put up his fist up to C1 and said. "you better get up or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated he told DSP-A, put his hands in the freezer and then outp is and shoukh is head no and shrinking away from DSP-A. DSP-B stated in January 2021, he observed DSP-A, put his hands on C1's neck and shoulders to wake him up while he was in his W/c, C1 was not happy, and shook and whimpered. DSP-A looked at DSP-B ataled there	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM 01614 B. WING 05/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCY ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER CONSERTERATION FOR SUPPLIER SUMMARY STATEMENT OF DEFICIENCY ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER CONSERTERATION FOR SUPPLIER Continued From page 4 5 815 During an interview 4/30/21, at 9:45 a.m. house supervisor (HS) stated she was informed of the incident that occurred on 4/27/21, by her supervisor and was informed the hospice nurse was afraid of DSP-A after she overheard what he said. The hospice nurse finished her visit, left and called the nurse at the house. The HS stated she was off that day so she did not make a report to the state agency and was unsure who made the report. During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that dory or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated her that day and the house is and in the freezer and then cup his hands around C1's neck and C1 was upset by this and shook his head no and shrinking away from DSP-A, DSP-B stated in January 2021, he observed DSP-A put his hands in the snow and come

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		01614	B. WING			C 04/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MTAI TR	ILLIUM		GATE DRIVE D, MN 55395	e, PO BOX 246		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
5 815		DSP-B felt bullied and	5 815			
	company's internal completed the facil that occurred. Thre investigation of the found out there we who were bullied by incidents and shou	v on 4/30/21, at 12:52 p.m. the investigator stated he ity investigations of incidents ough the course of the verbal abuse on 4/27/21, he re other incidents and staff y DSP-A and did not report Id have immediately informed report could be made to the				
	DSP-C stated she abuse C2 twice. DS assist of one but co DSP-C stated the f February 2021 whil "get the fuck up" ar March 2021 when "you fucking little b either one of the in "Oh just go tell you then stated her mo tried to deal with it	v on 4/30/21, at 1:04 p.m., observed DSP-A verbally SP-C stated C2 was blind and ould hear and understand. irst incident occurred in le DSP-A got C2 up he said nd the second one was in DSP-C overheard DSP-A say, itch". DSP-C did not report cidents because DSP-A said, r mommy about this". DSP-C ther was the HS and felt she on her own and told DSP-A to he was unaware of the ability the SA directly.				
	licensed practical r informed by the ho DSP-A and C1 on 4 receive the calls at	v on 5/3/21, at 10:00 a.m. hurse (LPN)-A stated she was spice nurse of the incident with 4/27/21, and usually did not bout any incidents and did not he state agency and did not to.				
innesota D		/ on 5/3/21, at 12:00 p.m. trator stated these incidents				

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		01614	B. WING		C 05/04/2021	
AME OF F	PROVIDER OR SUPPLIER	•	DDRESS, CITY, SI			
			STGATE DRIVE			
ITAI TRI		WINSTE	D, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMP THE APPROPRIATE DA	
5 815	Continued From pa	ige 6	5 815			
	should have been r immediately by the	reported to the stated agency facility.				
	Internal Review Po it was the policy of adults served by th considered vulnera require the reportin In addition the reportin immediately.	Maltreatment Reporting and licy reviewed 8/2018, indicated Mary T. Inc to protect the is program who are ble to maltreatment and to g of suspected maltreatment. ort indicated you must report R CORRECTION: Twenty-one				
	(21) days.					

		AND HUMAN SERVICES			FORM	APPROVED	
		& MEDICAID SERVICES				0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24G467	B. WING			C 05/04/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	ILLIUM			306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 00	accepted and approv	red 6/4/	21 SG	
	was conducted 5/3, the Minnesota Dep compliance with Er	sed Infection Control survey /21 to 5/4/21, at your facility by artment of Health to determine nergency Preparedness 75. The facility was in full					
W 000	INITIAL COMMEN	TS	W 00				
	survey was comple complaint investiga compliance with 42 requirements for In	h 5/4/21, 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.					
	HG467009C (MN7) deficiencies issued	2340) was substantiated with at W122 and W127.					
	42 CFR 483.420 w	articipation: Client Protection as found not met. ivestigations W149, W153 was					
	An Immediate Jeop W127 on 4/30/21, a	pardy (IJ) was identified at at 4:25 p.m.					
LABORATOR	support profession placed his hands in house where C1 sl placed his hands o him up. On 4/27/2 DSP-A put his hands his hands around C at C1 to threaten C abuse C1. DSP-A C2 on two occasion	nuary 2021, when direct al (DSP)-A went outside and a the snow and came into the ept in his wheelchair and n C1's back and neck to wake 1, the following was observed: ds in the freezer and cupped C1's neck; DSP-A raised his fist 1 to get up; DSP-A verbally was also verbally abusive to ns in February 2021 and March DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	
0	thy Hanson			ential Admininstrator	6/	3/2021	

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.

PRINTED: 05/19/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE W 000 Continued From page 1 2021. DSP-A threatened and bulled DSP-B and DSP-C not to report these incidents of abuse. The facility was informed of the IJ on 4/30/21, at 4/25 p.m. The immediate jeopardy was removed on 5/3/21, at 4/15 p.m. when the facility placed the alleged staff on administrative leave and education was provided to staff on protocols to report when staff to client altercations and abuse were alleged or occurred. W 000 A full survey was conducted for the requirements of 42 CFR 483. Subpart I, for Intermediate Care Facilities for Individuals who are Intellectually Disabled (ICF/IID) on 5/3/21 and 5/4/21. The facility was found NOT to be in compliance. CLIENT PROTECTIONS CFR(s): 483.420 W122 W 122 W 122 CFR(s): 483.420 W 122 W 122 The facility must ensure that specific client protections requirements are met. W 122 W 122 This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 W 122 This policy includes both federal and state reporting requirements. This policy includes both federal and state reporting requirements.	CENTE	RS FOR MEDICARE	A MEDICAID SERVICES			<u> </u>		0920-0291
24G467 B. WING						COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE MTAI TRILLIUM 306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395 WINSTED, MN 55395 (C4) JD PREPX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCENCY MAST EL PRECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION) PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CACH OPERCENCY) COMPLET (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) W 000 Continued From page 1 W 000 2021. DSP-A threatened and bulled DSP-B and DSP-C not to report these incidents of abuse, The facility was informed of the IJ on 4/30/21, at 4:25 p.m. The immediate jeopardy was removed on 5/3/21, at 4:15 p.m. When the facility placed the alleged staff on administrative leave and education was provided to staff on protocols to report when staff to client altercations and abuse were alleged or occurred. W 122: The AP was removed from the schedule immediately upon management being aware of the accusations. After investigation the AP was removed from W 122 CFR(s): 483.420 W 122 The facility must ensure that specific client protections requirements are met. W 122 This CONDITION is not met as evidenced by: Based on interview and document review, the Contino of Participation at 42 CFR 483.420 This policy includes both federal and state reporting requirements. Callent Protection, was not met. The facility failed Contino of the training included definitions of maltreatment and the obligation of reporting. This policy includes both federal and state reporting requirements.			24G467	B. WING	3. WING			
MIAI TRULLIUM WINSTED, MN 55395 (%) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DORRES PLAN OF CORRECTION (EACH DORRECTIVE ACTIONS SHOULD BE REPLX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DORRECTIVE ACTIONS SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENTION (EACH DORRECTIVE ACTIONS (EACH DORRECTIVE ACTIONS (EACH DORRECTIVE ACTION (EACH	NAME OF	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PHÉRY TAG (EACH CORRECTVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉEX TAG (EACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Combining DEFICIENCY W 000 Continued From page 1 2021. DSP-A threatened and bulled DSP-B and DSP-C not to report these incidents of abuse. The facility was informed of the IJ on 4/30/21, at 4:25 p.m. The immediate jeopardy was removed on 5/3/21, at 4:15 p.m. when the facility placed the alleged staff on administrative leave and education was provided to staff on protocols to report when staff to client altercations and abuse were alleged or occurred. W 122: The AP was removed from the schedule immediately upon management being aware of the accusations. After investigation the AP was removed from U122: CLIENT PROTECTIONS CFR(s): 483.420 W 122: The AP was removed from the schedule immediately upon management being aware of the accusations. After investigation the AP was removed from W 122: CLIENT PROTECTIONS CFR(s): 483.420 W 122: The AP was removed from the schedule immediately upon management being aware of the accusations. After investigation the AP was removed from W 122: The AP was removed from the schedule immediately upon management being aware of the accusations. After investigation the AP was removed from W 122: The AP was removed from the schedule immediately upon management being aware of the accusations. After investigation the AP was removed from W 122: The AP was removed from the schedule immediately upon management being aware of the accusations. After investigation the AP was removed from W 122: The AP was removed from the obligation of reporting. This policy includes both federal and state reporting requirements.								
 2021. DSP-A threatened and bulled DSP-B and DSP-C not to report these incidents of abuse. The facility was informed of the IJ on 4/30/21, at 4:25 p.m. The immediate jeopardy was removed on 5/3/21, at 4:15 p.m. when the facility placed the alleged staff on administrative leave and education was provided to staff on protocols to report when staff to client aftercations and abuse were alleged or occurred. A full survey was conducted for the requirements of 42 CFR 483. Subpart I, for Intermediate Care Facilities for Individuals who are Intellectually Disabled (ICF/IID) on 5/3/21 and 5/4/21. The facility was found NOT to be in compliance. CLIENT PROTECTIONS CFR(s): 483.420 W 122 CHENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. W 122 The AP was removed from the schedule immediately upon management being aware of the accusations. After investigation the AP was removed from W 122 employment. All staff were retrained on the Vulnerable Adults Maltreatment Reporting and Internal Review Policy. The training included definitions of maltreatment and the obligation of reporting. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed in the obligation of reporting. 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE
 abuse by direct support professional (DSP)-A for 2 of 3 clients (C1 and C2) reviewed for abuse. Findings include: See W127 for additional information: The facility failed to protect 2 of 3 clients (C1 and C2) from physical/verbal abuse by a staff member (swearing at clients, cupping hand on throat and purposefully walking up a client with ice cold adware or Witness of the AP's actions have received documented individual counseling on their responsibility as a mandated reporter. The Designated Manager will monitor for compliance by randomly talking with staff and asking if they have any concerns. Correction date: 5/7/2021 		2021. DSP-A threa DSP-C not to repor The facility was info 4:25 p.m. The imm on 5/3/21, at 4:15 p the alleged staff on education was prov report when staff to were alleged or occ A full survey was co of 42 CFR 483. Sul Facilities for Individ Disabled (ICF/IID) of facility was found N CLIENT PROTECT CFR(s): 483.420 The facility must en protections required This CONDITION Based on interview Condition of Partici Client Protection, w to protect facility cli abuse by direct sup 2 of 3 clients (C1 a Findings include: See W127 for addi failed to protect 2 c physical/verbal abu (swearing at clients	atened and bulled DSP-B and to these incidents of abuse. formed of the IJ on 4/30/21, at nediate jeopardy was removed o.m. when the facility placed a administrative leave and vided to staff on protocols to o client altercations and abuse curred. onducted for the requirements bpart I, for Intermediate Care tuals who are Intellectually on 5/3/21 and 5/4/21. The IOT to be in compliance. FIONS hsure that specific client ments are met. is not met as evidenced by: v and document review, the ipation at 42 CFR 483.420 vas not met. The facility failed ients from physical and verbal oport professional (DSP)-A for ind C2) reviewed for abuse.		122	W122: The AP was removed the schedule immediately upon management being aware of accusations. After investigati the AP was removed from employment. All staff were retrained on the Vulnerable Adults Maltreatme Reporting and Internal Review Policy. The training included definitions of maltreatment ar the obligation of reporting. This policy includes both fede and state reporting requirement Additionally, the staff that were aware or witness of the AP's have received documented individual counseling on their responsibility as a mandated The Designated Manager will for compliance by randomly ta staff and asking if they have a	on the on ent w I ad eral eral ents. re actions reporte monite	er. or with

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

Facility ID: 01614

If continuation sheet Page 2 of 17

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETE C	IDENTIFICATION NUMBER		
24G467 B. WING 05/04/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 306 WESTGATE DRIVE, PO BOX 246 MTAI TRILLIUM WINSTED, MN 55395 WINSTED, MN 55395 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	A. BUILDING	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MTAI TRILLIUM STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES	24G467 B. WING		
MTAI TRILLIUM 306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		05/04/2021	
	CY MUST BE PRECEDED BY FULL PREFIX	LD BE COMPLETION	
 W 122 Continued From page 2 hands). In addition, the staff were builled and threatened by alleged perpetrator (AP) which left incidents unreported to the state agency or the facility policy. This resulted in an immediate jeopardy (IJ) to the health and safety of all 6 cilents who resided in the home. W 127 PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all cilents. Therefore, the facility must ensure that cilents are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to protect 2 of 3 cilents (C1 and C2) from physical/verbal abuse by a staff member (swearing at cilents, cupping hand on throat and purposefully walking up a cilent with ice cold hands). In addition, the staff were builled and threatened by alleged perpetrator (AP) which left incidents unreported to administration and cilents vulnerable to ongoing abuse for several months. This resulted in an immediate jeopardy (U) to the health and safety of all 6 cilents who resided in the home. The LJ began on 1/2/21, when direct support professional (DSP)-A was observed going outside and placed his hands in snow, then came into the house where C1 slept in his wheelchair. DSP-A placed his cold hands on C1's back and neck to wake him up. The program supervisor and residential administration and different residential administrator were informed of the LJ 	n, the staff were bullied and aged perpetrator (AP) which left ted to the state agency or the tion as required by law and is resulted in an immediate e health and safety of all 6 ad in the home. F CLIENTS RIGHTS a)(5) ensure the rights of all clients. cility must ensure that clients are bysical, verbal, sexual or use or punishment. is not met as evidenced by: ew and document review, the otect 2 of 3 clients (C1 and C2) bal abuse by a staff member ts, cupping hand on throat and ing up a client with ice cold n, the staff were bullied and aged perpetrator (AP) which left ted to administration and clients oing abuse for several months. n immediate jeopardy (IJ) to the of all 6 clients who resided in 1/2/21, when direct support P)-A was observed going outside inds in snow, then came into the slept in his wheelchair. DSP-A ands on C1's back and neck to e program supervisor and	upon of the gation the tment view ded t and ederal ements. were P's actions d heir ed reporter.	

Facility ID: 01614

If continuation sheet Page 3 of 17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A, BUILDING			(X3) DATE SURVEY COMPLETED	
240467		240467	B. WING			C		
24G467						05/	04/2021	
NAME OF PROVIDER OR SUPPLIER MTAI TRILLIUM				30	REET ADDRESS, CITY, STATE, ZIP CODE 6 WESTGATE DRIVE, PO BOX 246 INSTED, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 127	facility placed the a leave and education protocols of reporting altercations/abuse. Findings include: C1's Identification F 4/30/21, indicated F disability, had diffic could follow one to In addition his IFS if independently with with a single handle Prevention Plan (IA C1 could be abused than himself and has potentially dangero with verbally/physic was unlikely to report persons. Staff will situation. In addition able to report, how remember all the d staff were mandate suspected physical appropriate people C2's IFS dated 5/3, profound intellectua and had generalize further indicated sh transfers and indep dated 11/04/20, indi- identify potentially of verbal/physical abu	 3/21, at 4:15 p.m. when the lleged staff on administrative n was provided to staff on ng staff to client Face Sheet (IFS) dated he had moderate intellectual ulty to express himself and two step verbal commands. Indicated he fed himself a fork and spoon and drank ed mug. C1's Individual Abuse APP) dated 2/01/21, indicated d by others bigger/stronger ad inability to identify us situations, inability to deal cally aggressive persons and ort abuse to appropriate remove C1 from an unsafe on the IAPP indicated he was ever he may not fully etails of a situation, Trillium ad reporters and will report any abuse on [C1]'s behalf to the 	W	127	· · · · · · · · · · · · · · · · · · ·			
FORM CMS-2	defend herself from 567(02-99) Previous Versions		 i1	Faci	lity ID: 01614 If continu	ation shee	t Page 4 of 17	

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Facility ID: 01614

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				(X3) DAT	E SURVEY	
		A. BUILDING			С	
24G467				05/	04/2021	
NAME OF PROVIDER OR SUPPLIER MTAI TRILLIUM			STREET ADDRESS, CITY, STATE, ZIP CODE 306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
 knocked at front door time and got no answe and heard care giver (a FUCKER and "YOU YOU NEED TO EAT". C1 at the counter with ate. The group home the witnessed verbal a During an interview 4/3 supervisor (HS) stated incident that occurred supervisor and was inf was afraid of DSP-A a said. The hospice nur and called the nurse a incident. During an interview on DSP-B stated he work on the day shift. DSP- irritated that day. DSF he got up C1, who was entered the room and said, "you better get up these". C1 shunned a DSP-B stated he told I to say that to him?" an walked away. DSP-B at lunch time, he obse in the freezer and ther neck and C1 was upse head no and shrunk av stated in January 2021 his hands in the snow 	nt Intake Form dated indicated a hospice nurse on 4/27/21, around lunch er. They entered the home (DSP-A) say to (C1)"You are ARE PISSING ME OFF, Hospice nurse observed DSP-A next to him while he nurse was made aware of abuse by the hospice nurse. 30/21, at 9:45 a.m. house d she was informed of the on 4/27/21, by her formed the hospice nurse fifter she overheard what he rse finished her visit, left at the house to report the n 4/30/21, at 10:23 a.m. and with DSP-A on 4/27/21, -B stated DSP-A was P-B stated that morning as	W 1				

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

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-0391

	S FUR MEDICARE				<u> </u>	NUD NO.	0920-0291
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR		Сом	E SURVEY PLETED
		24G467	B. WING	B. WING			C 0 4/2021
NAME OF PROVIDER OR SUPPLIER MTAI TRILLIUM			-1	306 WEST	DRESS, CITY, STATE, ZIP CODE GATE DRIVE, PO BOX 246 , MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOUL ISS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 127	happy, and shook a at DSP-B and laug another incident in observed DSP-A put front of him and sa make his bed. C1 and shook his head stated he was afrai because DSP-A tol would happened to report but felt bullie did not report the ir During an interview company's internal completed an interview company's internal completed an interview company's internal completed an interview company's internal completed an interview buring an interview ostaff were bullied b incidents. They sh informed managen to the state agency During an interview DSP-C stated she abuse C2 twice. DS assist of one but co DSP-C stated the f February 2021 when "you fucking little b either one of the in "Oh just go tell you then stated her fan felt she tried to dea	he was in his w/c, C1 was not and whimpered. DSP-A looked hed. DSP-B stated there was March 2021, where he unch C1's teddy bear right in id this was how to get C1 to was upset and said "No! No!" d and made his bed. DSP-B id to report these incident Id DSP-B if he reported, things o him. DSP-B knew he should ed and threatened by DSP-A so ncidents. v on 4/30/21, at 12:52 p.m. the i investigator stated the facility nal investigation of the alleged rough the course of the e verbal abuse on 4/27/21, they other incidents by DSP-A but by DSP-A and did not report would have immediately nent so a report could be made		127			
FORM CMS-2	567(02-99) Previous Versions		 ₹11	Facility ID: 016	14 If continu	lation shee	L t Page 6 of 17

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Facility ID: 01614

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	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		A, BUILC	A. BUILDING			PLETED
	24G467	B. WING	P-11/2	C 05/04/2021		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
MTAI TRILLIUM			306 WESTGATE DRIVE, PO E	3OX 246		
			WINSTED, MN 55395			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD	BE	(X5) COMPLETION DATE
During interview 4/3 stated when he ass was on his cell phot call and he was over DSP-A stated he ra he normally did not because his car wa he has never verba the clients. A Vulnerable Adults Internal Review Pol it is the policy of Ma served by this progrevulnerable to maltree reporting of suspect The immediate jeop was removed on 5/3 could be verified by review the facility has perpetrator on admi was provided to sta shift, updated their who to report abuse altercations occurree All staff were intervit other allegations of any other staff. Sta Vulnerable Adult Ma Internal Review Pol and state requirement the home were eval harm. The above it 5/3/21, from 12:00 pt	a report to the SA directly. 30/21, at 2:11 p.m. DSP-A sisted C1 to eat on 4/27/21, he ne with an important phone erheard by the hospice nurse. rely swore and he said words say to the collision center is being fixed. DSP-A stated Ily or physically abused any of Maltreatment Reporting and licy reviewed 8/2018, indicated ary T. Inc. to protect the adults ram who are considered eatment and to require the	W -		-NCY)		
FORM CMS-2567(02-99) Previous Versions	obsolete Event ID: X0UR17	1	Facility ID: 01614	If continuet	tion sheet	Page 7 of 17
PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEME	VT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION (X3) DATE SUF		
			A. BUILDING	NGC		
		24G467	B. WING		05/0	04/2021
	F PROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 06 WESTGATE DRIVE, PO BOX 246 VINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 12 W 14	 received. STAFF TREATMENCE CFR(s): 483.420(d) The facility must depolicies and proceder mistreatment, negled This STANDARD is Based on interview facility failed to imperior facility failed to imperior edures consist that direct staff to interview facility failed to imperior edures consist that direct staff to interview facility failed to imperior edures consist that direct staff to interview facility failed to imperior edures consist that direct staff to interview facility failed to imperior edures consist that direct staff to interview facility failed to imperior edures consist that direct staff to interview facility failed to imperior edures consist that direct staff to interview facility failed to imperior edures consist that direct staff to interview face. The group how the witnessed verber of the witne	NT OF CLIENTS)(1) evelop and implement written lures that prohibit ect or abuse of the client. s not met as evidenced by: v and document review, the lement abuse policies and ent with federal regulations mmediately report alleged staff itate Agency (SA) for 2 of 3) who was verbally and		W149: The AP was removed the schedule immediately up management being aware of accusations. After investiga the AP was removed from employment. All staff were retrained on th Vulnerable Adults Maltreatm Reporting and Internal Revie Policy. The training include definitions of maltreatment a the obligation of reporting. This policy includes both fed and state reporting requirem Additionally, the staff that we aware or witness of the AP's have received documented individual counseling on their responsibility as a mandated The Designated Manager wif for compliance by randomly staff and asking if they have Correction date: 5/7/2021	oon f the tion e ent ew d nd eral ents. ere action r I repor Il moni talking	ter. tor with

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

Facility ID: 01614

If continuation sheet Page 8 of 17

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-0391

A. BUILDING C 24G467 B. WING 05/04/202		
)21	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MTAI TRILLIUM 306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395		
	(X5) PLETION DATE	
W 149 Continued From page 8 stated she was off that day so she did not make a report to the state agency and was unsure who made the report. W 149 During an interview on 4/30/21, at 10:23 a.m. DSP-B stated he worked with DSP-A on 4/27/21, on the day shift. DSP-B stated DSP-A was irritated that day. DSP-B stated that moming as he got up C1, who was assist of 2, DSP-A entered the room and put up his fist up to C1 and said, "you better get up or your gonna get one of these". C1 shunned away from DSP-A's fist. DSP-B stated he told DSP-A, "Why did you have to say that to htm?" and DSP-A glared at him and walked away. DSP-B sthen stated later that day, at lunch time, he observed DSP-A, put his hands in the freezer and then cup his hands around C1's neck and C1 was upset by this and shook his head no and shrinking away from DSP-A, DSP-B stated in January 2021, he observed DSP-A put his hands on C1's neck and shoulders to wake him up while he was in his w/c, C1 was not happy, and shook and whimpered. DSP-A looked at DSP-B and larghed. DSP-B stated there was another incident in March 2021, where he observed DSP-A punch C1's leddy bear right in front of him and said this was how you goi C1 to make his bed. C1 was upset and said "NoI NoI" and shook his head and made his bed. DSP-B stated he was afraid to report things because DSP-A built DSP-B filt elulied and threatened by DSP-A. During an interview on 4/30/21, at 12:52 p.m. the comparys internal investigator stated he completed the facility investigators stated he completed the facility investigators fasted he completed		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	IEDICARE		SERVICES					0920-0281
STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SU IDENTIFICATIO				E CONSTRUCTION	Сом	E SURVEY PLETED
		240	6467	B. WING			1	C 04/2021
NAME OF PROVIDER O	R SUPPLIER	1			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1	
					30	6 WESTGATE DRIVE, PO BOX 246		
MTAI TRILLIUM					W	INSTED, MN 55395		
PREFIX (EACH	I DEFICIENC	ATEMENT OF DEFIC Y MUST BE PRECEL .SC IDENTIFYING IN	ED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
investiga found ou who were incidents manager state age During at DSP-C s abuse C assist of DSP-C s February "get the f March 20 "you fuck either on "Oh just then stat tried to d stop. Sh to make During a licensed informed DSP-A a receive t make a n know sh During ir administ been rep by the fa	t there we bullied b and shout nent so a ency. In interview tated she 2 twice. Di- one but ce tated the f v 2021 whi fuck up" a 021 when cing little b e of the in go tell you ed her mo- eal with it is stated s a report to by the hor nd C1 on he calls al report to the e needed nterview 5, rator state ported to the cility. able Adult Review Po-	verbal abuse o re other inciden y DSP-A and div ld have immedi report could be v on 4/30/21, at observed DSP- SP-C stated C2 ould hear and u first incident occ le DSP-A got C2 ould hear and u first incident occ DSP-C overhea- bitch". DSP-C div or the second co DSP-C overhea- bitch". DSP-C div or her own and she was unawar o the SA directly w on 5/3/21, at 18 outher was the HS on her own and she was unawar o the SA directly w on 5/3/21, at 12 outher agency to. /3/21, at 12:00 p ed these inciden he stated agence s Maltreatment olicy reviewed 8	ts and staff d not report ately informed made to the 1:04 p.m., A verbally was blind and nderstand. curred in 2 up he said one was in and DSP-A said, it dnot report e DSP-A said, t this". DSP-C S and felt she t told DSP-A to e of the ability c. 0:00 a.m. tated she was he incident with ually did not and did not and did not and did not com. residential ts should have y immediately Reporting and /2018, indicated	W	149			
FORM CMS-2567(02-99) Pro	-	lary T. Inc to pro	Event ID: X0UR1	 1	Fac	sility ID: 01614 If contin	uation sheet	Page 10 of 17

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
	24G467 B. WING			C 05/04/2021		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 306 WESTGATE DRIVE, PO BOX 246 WINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
W 149	served by this prog vulnerable to maltre reporting of suspect the report indicated STAFF TREATMEN CFR(s): 483.420(d) The facility must en mistreatment, negle injuries of unknown immediately to the officials in accordar established proced This STANDARD is Based on interview facility failed to imm abuse to the design of 3 clients (C1 and of abuse. Findings include: C1's Identification F 4/30/21, indicated h disability, had diffice could follow one to In addition his IFS i independently with with a single handle Prevention Plan (IA C1 could be abused than himself and ha potentially dangerod with verbally/physic	ram who are considered eatment and to require the ted maltreatment. In addition you must report immediately. IT OF CLIENTS (2) sure that all allegations of ect or abuse, as well as source, are reported administrator or to other nce with State law through	W 14	 ³³ W 153 Effective immediately and on-going basis, all allega mistreatment, neglect, or will be immediately repor the Administer or the stat directly. The Administrator will as that State Agency be cor as required. Direct Service Professionals and Servic Coordinator were provide additional training on VA which includes the immer reporting all accusations suspected abuse or negli injuries of unknown origin any significant medication to the Administrator and/MAARC. The Designated Manage monitor for compliance. Completion date: 	tions of abuse ted to te agency sure tacted e e diacy of of ect, n or n error or to r will	

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

Facility ID: 01614

If continuation sheet Page 11 of 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TO FUR MEDICARE						0930-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	CON	E SURVEY IPLETED
		24G467	B. WING	i			C 04/2021
NAME OF	PROVIDER OR SUPPLIER	1		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
					6 WESTGATE DRIVE, PO BOX 246		
MTAI TR	ILLIUM				NSTED, MN 55395		
					PROVIDER'S PLAN OF CORRECT		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 153			w	153			
	profound intellectua and had generalize further indicated sh transfers and indep dated 11/04/20, ind identify potentially of	/21, indicated she had al disabilities, was legally blind ad anxiety disorder. The IFS ne was assist of one with bendent to walk. C2's IAPP dicated she had inability to dangerous situations and use. In addition C2's IAPP					
	indicated she would defend herself from	d not be able to report or n maltreatment.					
	4/27/21, at 12:45 p knocked at front do time and got no an heard care giver [D FUCKER and "YOU YOU NEED TO EA C1 at the counter v ate. The group hou	Point Intake Form dated .m. indicated a hospice nurse bor on 4/27/21, around lunch swer, entered the home and OSP-A] say to [C1] "You are a U ARE PISSING ME OFF, AT". Hospice nurse observed with DSP-A next to him while he me nurse was made aware of bal abuse by the hospice nurse.					
	supervisor (HS) sta incident that occurn supervisor and was was afraid of DSP- said. The hospice and called the nurs stated she was off report to the state a made the report.	v 4/30/21, at 9:45 a.m. house ated she was informed of the red on 4/27/21, by her s informed the hospice nurse A after she overheard what he nurse finished her visit, left se at the house. The HS that day so she did not make a agency and was unsure who	L				
	DSP-B stated he w on the day shift. D irritated that day. I he got up C1, who	v on 4/30/21, at 10:23 a.m. vorked with DSP-A on 4/27/21, oSP-B stated DSP-A was DSP-B stated that morning as was assist of 2, DSP-A					
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: X0UR	.11	Facil	lity ID: 01614 If continu	lation sheet	Page 12 of 17

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY	
		24G467	B. WING				C 04/2021
NAME OF	PROVIDER OR SUPPLIER	I	I	30	TREET ADDRESS, CITY, STATE, ZIP CODE 06 WESTGATE DRIVE, PO BOX 246 VINSTED, MN 55395	1 05/	04/2021
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 153	entered the room a said, "you better ge these". C1 shunne DSP-B stated he to to say that to him?" walked away. DSP at lunch time, he ob in the freezer and th neck and C1 was u head no and shrink stated in January 2t his hands in the smo put his hands on C1 wake him up while happy, and shook a at DSP-B and laugh another incident in observed DSP-A pu front of him and sai make his bed. C1 v and shook his head stated he was afraid DSP-A told DSP-B happened to him. If threatened by DSP- During an interview company's internal completed the facilit that occurred. Thro investigation of the found out there wer who were bullied by incidents and shoul management so a r state agency.	nd put up his fist up to C1 and to up or your gonna get one of d away from DSP-A's fist. Id DSP-A, "Why did you have and DSP-A glared at him and P-B then stated later that day, oserved DSP-A put his hands hen cup his hands around C1's pset by this and shook his ing away from DSP-A. DSP-B 021, he observed DSP-A put ow and come in the house and 1's neck and shoulders to he was in his w/c, C1 was not and whimpered. DSP-A looked hed. DSP-B stated there was March 2021, where he unch C1's teddy bear right in d this was how you got C1 to was upset and said "No! No!" I and made his bed. DSP-B d to report things because if he reported, things would DSP-B felt bullied and	W	153			

Facility ID: 01614

PRINTED:	05/19/2021
FORM	APPROVED
OMB NO	0038-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTIC			E SURVEY PLETED	
		24G467	B. WING			C 05/04/2021		
NAME OF F	PROVIDER OR SUPPLIER	J	1		S, CITY, STATE, ZIP CODE DRIVE, PO BOX 246 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH C	DER'S PLAN OF CORRECT CORRECTIVE ACTION SHO EFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 153	abuse C2 twice. DS assist of one but co DSP-C stated the f February 2021 whil "get the fuck up" ar March 2021 when "you fucking little b either one of the in "Oh just go tell you then stated her mo tried to deal with it stop. She stated s to make a report to During an interview licensed practical r informed by the ho DSP-A and C1 on receive the calls at make a report to the know she needed to During an interview residential adminis should have been immediately by the A Vulnerable Adult Internal Review Po it was the policy of adults served by the considered vulnera require the reportin In addition the repo- immediately.	SP-C stated C2 was blind and buld hear and understand. irst incident occurred in le DSP-A got C2 up he said and the second one was in DSP-C overheard DSP-A say, itch". DSP-C did not report cidents because DSP-A said, r mommy about this". DSP-C ther was the HS and felt she on her own and told DSP-A to he was unaware of the ability o the SA directly. v on 5/3/21, at 10:00 a.m. hurse (LPN)-A stated she was spice nurse of the incident with 4/27/21, and usually did not bout any incidents and did not to. v on 5/3/21, at 12:00 p.m. trator stated these incidents reported to the stated agency e facility. s Maltreatment Reporting and blicy reviewed 8/2018, indicated Mary T. Inc to protect the his program who are able to maltreatment and to ng of suspected maltreatment. ort indicated you must report RATION	W 1					
EORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: X0UR		Facility ID: 01614	If cont	inuation sheet	Page 14 of 1	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G467		B. WING				
NAME OF I	PROVIDER OR SUPPLIER	240407	D. WINC		TREET ADDRESS, CITY, STATE, ZIP CODE	05/	04/2021	
MTAI TR				3	06 WESTGATE DRIVE, PO BOX 246 VINSTED, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 369	that all drugs, inclusion self-administered, and self-administered, and self-administered, and self-administered (GT) to prevent pot accordance to accept or 2 of 6 clients (Comedication administered (GT) to prevent pot accordance to accept of 2 of 6 clients (Comedication administered) (GT) to prevent pot accordance to accept of 2 of 6 clients (Comedication administered) (GT) to prevent pot accordance to accept of 2 of 6 clients (Comedication administered) (GT) to prevent pot accordance to accept of 2 of 6 clients (Comedication administered) (GT) to prevent pot administered and was fed throug anything by mouth and was fed throug anything by mouth and was fed throug anything by mouth and the self at a self administered (DSP)-D was observed and the poure administered (GSP)-D was observed and the poure administered (GSP)-D was observed a cup of the poure administered (GSP)-D was observed and the poure administered (GSP)-D was observed a cup of the poure administered (GSP)-D was observed and the poure administered (GSP)-D was o	g administration must assure ding those that are are administered without errors s not met as evidenced by: tion, interview and document ailed to ensure medications separately via gastric tube ential adverse interactions in eptable professional standard 6 and C4) reviewed for stration. Face Sheet dated 4/3/2021, profound intellectual disability h a G-tube and did not take due to aspiration risk. of medication pass on m., direct support profession rved to set up C6's D opened a bottle of tegretol ation) and poured 10 o a clear medication cup, and Pyrex measuring cup that water. DSP-D then proceeded (diuretic) and 1 scoop of n powder) and poured into th ixed them all together. DSP- oom. Flushed 125 ml of wat ity flow, then gave medication cup of water by gravity and water.	r. s al ed e D er ns	369 Fac	The program LPN consulted the primary physicians of C6 C4. The physician ordered the medications could be giv via G-tube at the same time Going forward, if new Gtube are recieved, or meds are co for the current residents on the LPN will consult with the for instructions. The RN will monitor for com Correction date: 5/7/2021	5 and that /en e order nange gtubes e physi	d s, cian	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	05/19/2021
FORM	APPROVED
OMB NO	0038-0301

						T	0300-0031
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24G467	B. WING	3			C 04/2021
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	0-7/L0L1
				:	306 WESTGATE DRIVE, PO BOX 246		
MTAI TRIL	LIUM			'	WINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	'IX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
	medications togeth C4's Identification F indicated she was p and was gastric tub C4's current signed 10/05/2020, indicat one tablet daily, pre capsule daily, levet ml daily, Zyprexa (a ondansetron (preve During interview 5/- manager (PM) state G-tubes and receiv through the G-tube further stated she v LPN-A the procedu During interview 5/- Geritom pharmacy he was not aware t together. Pharm-C of practice to give r time due to the pot During interview 5/- stated she was una be given all togethe stomach. Facility procedure of Care undated, india "Check with the ph that the pills may b same time. Also c	s "ok to give all of the	W	369			

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

Facility ID: 01614

If continuation sheet Page 16 of 17

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PRINTED: 05/19/2021
FORM APPROVED
OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NU			TIPLE CONS		(X3) DATE SURVEY COMPLETED	
		24G467	B. WING			C 05/04/2021	
NAME OF F	PROVIDER OR SUPPLIER	I	1	306 WES	ADDRESS, CITY, STATE, ZIP CODE S TGATE DRIVE, PO BOX 246 E D, MN 55395	, 00/	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x c	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 369	with the pharmacist	Ige 16 v procedure indicated to check t or nurse to give medications DSP-D gave medications	W :	369	DEFICIENCY)		
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: X0UR1	1	Facility ID: 0	1614 If continuati	on sheet I	Page 17 of 17

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: С B. WING 01614 05/04/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 306 WESTGATE DRIVE, PO BOX 246 **MTAI TRILLIUM** WINSTED, MN 55395 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 5 000 Initial Comments 5 0 0 0 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 4/29/21 through 5/4/21, surveyor of this In accordance with Minnesota Statute, Department visited the above provider and the section 144.56 and/or Minnesota Statute. following correction order was issued. When section 144.653, this correction order has corrections are completed, please sign and date, been issued pursuant to a survey. If, upon make a copy of these orders and return the reinspection, it is found that the deficiency original to: or deficiencies cited herein are not corrected, a fine for each violation not Minnesota Department of Health corrected shall be assessed in Health Regulation Division accordance with a schedule of fines Licensing and Certification Program promulgated by rule of the Minnesota 85 East 7th Place Department of Health. Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE athy Hanson, RA

Residential Administrator 6/3/2021 X0UR11

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
01614				·	C 05/04/2021	
	PROVIDER OR SUPPLIER	. .		STATE, ZIP CODE	03/0	4/2021
				/E, PO BOX 246		
MTAI TR		WINSTED	, MN 55395	5		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
5 000	Continued From pa	age 1	5 000			
	Suite 220 Attention: Sarah G St Paul MN 55164 or email Sarah Gre sarah.grebenc@st	ebenc at		Determination of whether a viola been corrected requires complia all requirements of the rule provi tag number and MN Rule number Statute indicated below. When a statute contains several items, fa comply with any of the items will considered lack of compliance. compliance upon re-inspection v item of multi-part rule will result i assessment of a fine even if the was violated during the initial ins was corrected. You may request a hearing on an assessments that may result fro non-compliance with these order provided that a written request is the Department within 15 days of of a notice of assessment for non-compliance.	nce with ded at the er or MN a rule or ailure to be Lack of vith any n the item that pection	
5 815	(a) A mandated rep believe that a vulne been maltreated, o vulnerable adult ha which is not reason immediately report common entry poin vulnerable adult so admitted to a facili required to report so individual that occu unless:	57 Subd. 3. VA Timing of report. porter who has reason to erable adult is being or has or who has knowledge that a as sustained a physical injury nably explained shall t the information to the nt. If an individual is a olely because the individual is ty, a mandated reporter is not suspected maltreatment of the urred prior to admission, was admitted to the facility from d the reporter has	5 815			

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: С B. WING 01614 05/04/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 306 WESTGATE DRIVE, PO BOX 246 MTAI TRILLIUM WINSTED, MN 55395 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX **REGULATORY OR LSC IDENTIFYING INFORMATION)** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 5815 Continued From page 2 5 8 1 5 reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has 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 2 of 3 clients (C1 and C2) reviewed for allegations

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Minneso	ta Department of He	ealth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY
7.110 / 2/11			A. BUILDING:			
		01614	B. WING			,)4/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MTAI TR	ILLIUM		TGATE DRIV), MN 55395	E, PO BOX 246		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
5 815	Continued From pa	age 3	5 815			
	of abuse.					
	Findings include:					
	4/30/21, indicated I disability, had diffic could follow one to In addition his IFS independently with with a single handle Prevention Plan (IA C1 could be abuse than himself and his potentially dangero with verbally/physic	Face Sheet (IFS) dated the had moderate intellectual ulty to express himself and two step verbal commands. indicated he fed himself a fork and spoon and drank ed mug. C1's Individual Abuse APP) dated 2/01/21, indicated d by others bigger/stronger ad inability to identify thus situations, inability to deal cally aggressive persons and ort abuse to appropriate				
	profound intellectua and had generalized further indicated sh transfers and indep dated 11/04/20, indi identify potentially verbal/physical abu	/21, indicated she had al disabilities, was legally blind ed anxiety disorder. The IFS ne was assist of one with bendent to walk. C2's IAPP dicated she had inability to dangerous situations and use. In addition C2's IAPP d not be able to report or n maltreatment.				
	4/27/21, at 12:45 p knocked at front do time and got no an heard care giver [E FUCKER and "YO YOU NEED TO EA C1 at the counter v ate. The group ho	Point Intake Form dated o.m. indicated a hospice nurse oor on 4/27/21, around lunch swer, entered the home and OSP-A] say to [C1] "You are a U ARE PISSING ME OFF, AT". Hospice nurse observed with DSP-A next to him while he me nurse was made aware of oal abuse by the hospice nurse.				
Minnesota D STATE FOR	Department of Health M	/	6899	X0UR11	lf continua	ation sheet 4 of 3

			CONSTRUCTION		E SURVEY PLETED		
	01614			B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
		306 WES	TGATE DRIVE	, PO BOX 246			
MTAI TR		WINSTEI	D, MN 55395				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLE DATE	
				DEFICIEN	CY)		
5 815	Continued From pa	age 4	5 815				
	supervisor (HS) sta incident that occurr supervisor and was was afraid of DSP- said. The hospice and called the nurs stated she was off	v 4/30/21, at 9:45 a.m. house ated she was informed of the red on 4/27/21, by her s informed the hospice nurse A after she overheard what he nurse finished her visit, left se at the house. The HS that day so she did not make a agency and was unsure who					
	DSP-B stated he w on the day shift. D irritated that day. If he got up C1, who entered the room a said, "you better get these". C1 shunne DSP-B stated he to to say that to him?" walked away. DSF at lunch time, he of in the freezer and t neck and C1 was u head no and shrink stated in January 2 his hands in the sn put his hands on C wake him up while happy, and shook a at DSP-B and laug another incident in observed DSP-A pu front of him and sa make his bed. C1	v on 4/30/21, at 10:23 a.m. vorked with DSP-A on 4/27/21, SP-B stated DSP-A was DSP-B stated that morning as was assist of 2, DSP-A and put up his fist up to C1 and et up or your gonna get one of ed away from DSP-A's fist. old DSP-A, "Why did you have ' and DSP-A glared at him and P-B then stated later that day, oserved DSP-A put his hands hen cup his hands around C1's upset by this and shook his sing away from DSP-A. DSP-B 021, he observed DSP-A put ow and come in the house and 1's neck and shoulders to he was in his w/c, C1 was not and whimpered. DSP-A looked hed. DSP-B stated there was March 2021, where he unch C1's teddy bear right in id this was how you got C1 to was upset and said "No! No!" d and made his bed. DSP-B					

X0UR11

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 05/04/2021 01614 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 306 WESTGATE DRIVE, PO BOX 246 MTAI TRILLIUM WINSTED, MN 55395 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 5815 5 815 Continued From page 5 happened to him. DSP-B felt bullied and threatened by DSP-A. During an interview on 4/30/21, at 12:52 p.m. the company's internal investigator stated he completed the facility investigations of incidents that occurred. Through the course of the investigation of the verbal abuse on 4/27/21, he found out there were other incidents and staff who were bullied by DSP-A and did not report incidents and should have immediately informed management so a report could be made to the state agency. During an interview on 4/30/21, at 1:04 p.m., DSP-C stated she observed DSP-A verbally abuse C2 twice, DSP-C stated C2 was blind and assist of one but could hear and understand. DSP-C stated the first incident occurred in February 2021 while DSP-A got C2 up he said "get the fuck up" and the second one was in March 2021 when DSP-C overheard DSP-A say, "vou fucking little bitch". DSP-C did not report either one of the incidents because DSP-A said, "Oh just go tell your mommy about this". DSP-C then stated her mother was the HS and felt she tried to deal with it on her own and told DSP-A to stop. She stated she was unaware of the ability to make a report to the SA directly. During an interview on 5/3/21, at 10:00 a.m. licensed practical nurse (LPN)-A stated she was informed by the hospice nurse of the incident with DSP-A and C1 on 4/27/21, and usually did not receive the calls about any incidents and did not make a report to the state agency and did not know she needed to. During an interview on 5/3/21, at 12:00 p.m. residential administrator stated these incidents

Minnesota Department of Health STATE FORM

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If continuation sheet 6 of 7

Minneso	ta Department of He	ealth			,	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:	(X3) DATE COMP	SURVEY PLETED
	01614		B. WING			C)4/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY.	, STATE, ZIP CODE		
				VE, PO BOX 246		
MTAI TR	ILLIUM		, MN 5539			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
5 815	Continued From particular should have been reacting immediately by the A Vulnerable Adults Internal Review Point was the policy of adults served by the considered vulnerar require the reporting in addition the reporting immediately.	age 6 reported to the stated agency	5 815			
Minnesota D STATE FORI	epartment of Health		6899		If continue	ation sheet 7 of 7
SINCTON				X0UR11	ir continua	auon sneet 7 of 7



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email on May 19, 2021

Administrator Mtai Trillium 306 Westgate Drive, Po Box 246 Winsted, MN 55395

RE: Event ID: XOUR11

Dear Administrator:

On May 4, 2021, 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. This survey found one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the survey we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the electronically delivered "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy effective May 3, 2021.

One or more of these deficiencies do not meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID):

W122 42 CFR § 483.420 Client Protections

Federal certification deficiencies are delineated on the enclosed form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC).

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

- 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 correctionk will be completed.

Mtai Trillium May 19, 2021 Page 2

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 B 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 Office: (651) 201-3792

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

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by June 28, 2021, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

Sincerely,

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed on May 19, 2021

Administrator Mtai Trillium 306 Westgate Drive, Po Box 246 Winsted, MN 55395

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: XOUR11

Dear Administrator:

The above facility was surveyed on April 29, 2021 through May 4, 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.

Mtai Trillium

Page 2

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

Sarah Grebenc, Unit Supervisor Metro B 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 Office: (651) 201-3792

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.

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

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

Sincerely,

Kim Tyson

Fication Failed to protect W1ZZ - Failed to assive right to be Alter from PANALSA/Bych. Abuse mut W1ZT - Rights From PANALSA/Bych. Abuse mut Area from PANALSA/Bych. Abuse mut W1ZT - Failed to IMPlement Abuse policies W1ZT - Failed to IMPlement reporting W1ZT - Pailed to IMPlement reporting W1ZT - Failed to IMPlement Abuse policies W1ZT - Failed to IMPlement 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

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project (0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
24G467	MTAI TRILLIUM
Type of Survey (select all that apply)): A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanction/Hearing C Federal Monitoring G Validation K State License D Follow-up Visit H Life safety Code L Chow
xtent of Survey (Select all that appl	.y):
A A	A Routine/Standard (all providers/suppliers) B Extended Survey (HHA or long term care facility) C Partial Extended Survey (HHA)

D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. | Use the surveyor's information number.

1									
Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (Hours (H)	ff-Site Report Preparation Hours (I)	
Team Leader 1. 28598	04-30-2021	05-04-2021	1.50	0.00	15.50	0.00	3.00	16.00	
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

Cotal Supervisory Review Hours	5.00
Cotal Clerical/Data Entry Hours	2
Was Statement of Deficiencies given to the provider on-site at completion of the survey? \ldots	Ν

1

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project (0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name					
24G467	MTAI TRILLIUM					
Type of Survey (select all that apply)	A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanction/Hearing C Federal Monitoring G Validation K State License D Follow-up Visit H Life safety Code L Chow					
Extent of Survey (Select all that apply	:					
A A	A Routine/Standard (all providers/suppliers) B Extended Survey (HHA or long term care facility) C Partial Extended Survey (HHA)					

D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. | Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (Hours (H))ff-Site Report Preparation Hours (I)	
Team Leader 1. 28598	04-30-2021	05-04-2021	0.00	0.00	4.00	0.00	0.00	1.00	
2.									
3.									
4.									
5.									
6.									
7.									_
8.									
9.									
10.									

Total Supervisory Review Hours	1.75
Total Clerical/Data Entry Hours	3.25
Was Statement of Deficiencies given to the provider on-site at completion of the survey? \ldots	Ν