

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email on June 25, 2021

Administrator Range Center Aspenwood Home 1820 East 39th Street Hibbing, MN 55746

RE: Event ID: C2Q411

Dear Administrator:

On June 8, 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. At the time of the survey, the survey team noted one or more deficiencies.

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

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

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

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

Range Center Aspenwood Home

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:

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Email: william.abderhalden@state.mn.us

Office: 507-361-6204

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

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

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior Program Assurance | Licensing and Certification

Minnesota Department of Health P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-3831

Email: kim.tyson@state.mn.us

PRINTED: 06/25/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24G476	B. WING _		C 06/08/2021	
	PROVIDER OR SUPPLIER	D HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1820 EAST 39TH STREET HIBBING, MN 55746	1 00/	5072021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE RIATE	COMPLETION DATE
	completed at your finvestigation. Your for compliance with 42 requirements for Inflindividuals with Intel HG476002C (MN73 be SUBSTANTIATE W124, W331. As a result of the indeficiencies were in W155. PROTECTION OF CFR(s): 483.420(a) The facility must en Therefore the facility parent (if the client of the client's medic and behavioral state treatment, and of the This STANDARD is Based on interview agency failed to not weight loss for 1 of client rights. Findings include: C2's Coordinated S 5/13/21, indicated a year and identified a state of the coordinated S 13/21, indicated a year and identified a state of the coordinated S 13/21, indicated a year and identified a state of the coordinated S 13/21, indicated a year and identified a state of the coordinated S 13/21, indicated a year and identified a state of the coordinated S 13/21, indicated a year and identified a state of the coordinate of the co	an abbreviated survey was acility to conduct a complaint facility was NOT IN CFR Part 483, subpart I, termediate Care Facilities for ellectual Disabilities. 3321, MN73049) was found to ED with deficiencies cited at vestigation additional dentified at W149, W153 and CLIENTS RIGHTS (2) sure the rights of all clients. The symust inform each client, is a minor), or legal guardian, cal condition, developmental tus, attendant risks of the right to refuse treatment. Is not met as evidenced by: It and document review the citify guardians of a significant 2 clients (C2) reviewed for Services Support Plan date a decline health over the past an increase in	W 00	this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that	8/10	/21
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NAT.URE	TITLE		(X6) DATE

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		24G476	B. WING		 06	C 5/08/2021
	PROVIDER OR SUPPLIER CENTER ASPENWOO	D HOME		STREET ADDRESS, CITY, S 1820 EAST 39TH STREE HIBBING, MN 55746	STATE, ZIP CODE	70072021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S F X (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
W 124	tremors/shaking, wissues and a need staff. C2's Weight Recorweights: December 2020, 13 January 2021, 128 February 2021, 132 Ib May 2021, 118 lbs. A total of 16 lbs. ov During interview on p.m. C2's guardian visit C2 and had to her clothes were all the visit she had no COVID-19 pandem been notified of the	d identified the following 34 lbs. (pounds) lbs.	W	ICF/ID Weight completed whe greater than a a month. Nurs complete the forequired notific once complete by the Residen Nursing staff w trained on this utilize it. This forequired for a clients residing	5 lb. weight loss in sing staff will orm and make the cations. The form, d, will be reviewed tial Director. Here individually form and when to form will be all Range Center in ICF homes each greater than five lb. In month.	Completion Date: 7/10/21
W 149	individual homes. FC2's weight loss or 5/24/21. RN-A state assessments she was completed but did information and sa communicated at the stated she had not meetings. STAFF TREATMERCFR(s): 483.420(d) The facility must depolicies and process)(1) evelop and implement written	W	place for the re and maltreatme adults that inclu	nc., already has and procedures in porting of incidents ent of vulnerable udes mistreatment, e of clients. Please	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		PLE CONSTRUCTION	(X3) DAT	E SURVEY
							c
NAME OF		24G476	B. WING	_		06/	08/2021
	PROVIDER OR SUPPLIER CENTER ASPENWOO	D HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1820 EAST 39TH STREET HIBBING, MN 55746		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	Based on interview facility failed to imple reporting allegation (SA) for 1 of 1 clien Findings include: C2's Individual abust dated 5/13/21, indicabuse. The IAPP id reported and trained.	s not met as evidenced by: y and document review the lement their policy for s of abuse to the state agency t (C2) reviewed for abuse. se prevention plan (IAPP) cated she was susceptible to entified staff as mandated d biannually on vulnerable . The plan directed staff to	W	A staff meeting will be conducted at Aspenwood on July 23, 2021. The Reporting and Review of Maltreatment of Vulnerable Adults policies and procedures will be covered at this meeting along with a staff Q & A session. The Residential Program Supervisor and residential staff are aware that reporting of incidents or VA situations needs to be done immediately. In the Reporting and Review of Maltreatment policy is a list of maltreatment and what			
	During interview on 6/3/21, at 6:45 p.m. C2's guardian (G)-A stated C2 had called her on the phone upset and crying. G-A stated C2 and the qualified intellectual disabilities professional (QIDP) "got into it about her (C2)'s favorite cup. G-A stated she had received a call from C2, upset every night this week. G-A stated she asked C2 to put the phone in her lap and go out and ask the QIDP to help her get a cup of water. G-A stated the QIDP was talking down to C2, telling her she couldn't have a cup of water in her room and the cup had to stay in the kitchen. G-A stated C2 just wanted a cup of water in her room and said, "she was crying so hard." G-A said "I feel like she is being abused." G-A stated she believed the QIDP went into C2's room and went through her stuff. G-A stated "something is going on, I'm convinced of it." "She's crying out for				needs to be reported is described. The Reporting and Review of Maltreatment of Vulnerable Address will be covered again semi-annually. Each new staff member is trained on the VA an incident reporting policies as the are hired. Persons Responsible: QIDP & Nursing	ults d	Completion Date:
	help." G-A stated th	e QIDP pushed C2's buttons s which ones to push."				•	1 4 4 5 4 4

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G476	B. WING		<u> </u>	06/0) 08/2021
NAME OF F	PROVIDER OR SUPPLIER	*		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	J0/2021
RANGE (CENTER ASPENWOO	D HOME			820 EAST 39TH STREET IBBING, MN 55746	v	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149		a.m. the agency chief (CEO) was notified of the	W 1	49			
	let the director of re about the allegation resources. The CEO the allegation to the was why the survey CEO stated typically	o.m. the CEO stated she had sidential services (DRS) know and had also notified human O stated she had not reported a SA because she thought that for was at the agency. The y when an allegation of abuse rould report it to the SA					
W 153	The agency's abuse provided. STAFF TREATMEN CFR(s): 483.420(d)		W 1	53			
	The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of abuse to the state agency (SA) for 1 of 1 client (C2) reviewed for abuse.				Range Center, Inc., already has written policies and procedures place for the reporting of incider and maltreatment of vulnerable adults that includes mistreatment	nts	
					neglect or abuse of clients. Plea see attached policies.	se	
	Findings include:						
	dated 5/13/21, indi	se prevention plan (IAPP) cated she was susceptible to staff to report allegations of					

	OF DEFICIENCIES OF CORRECTION	I IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		24G476	B. WING		00	C 6/ 08/2021	
	PROVIDER OR SUPPLIER CENTER ASPENWOO	DD HOME		STREET ADDRESS, CITY, STATE, Z 1820 EAST 39TH STREET HIBBING, MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 153	abuse. During interview or guardian (G)-A state phone upset and ciqualified intellectual (QIDP) "got into it a G-A stated she had upset every night the asked C2 to put the and ask the QIDP to G-A stated the QIDP to G-A stated the QIDP to telling her she coul room and the cup her stated C2 just want and said, "she was feel like she is bein believed the QIDP through her stuff. Gon, I'm convinced to help." G-A stated the and said "she know On 6/4/21, at 10:58 engineering officer allegation of abuse On 6/7/21, at 1:26 plet the director of reabout the allegation resources. The CE the allegation to the was why the survey CEO stated typicall was received she was stated to the control of the course o	in 6/3/21, at 6:45 p.m. C2's seed C2 had called her on the rying. G-A stated C2 and the all disabilities professional about her (C2)'s favorite cup. If received a call from C2, his week. G-A stated she as phone in her lap and go out to help her get a cup of water. In was talking down to C2, dn't have a cup of water in her had to stay in the kitchen. G-A sted a cup of water in her room crying so hard." G-A said "I g abused." G-A stated she went into C2's room and went G-A stated "something is going of it." "She's crying out for the QIDP pushed C2's buttons we which ones to push."	W 1	A staff meeting will be at Aspenwood on July The Reporting and Rem Maltreatment of Vulnipolicies and procedure covered at this meeting a staff Q & A session. Residential Program S and residential staff at that reporting of incides ituations needs to be immediately. In the Review of Maltreatment at needs to be reported. The Reporting and Rem Maltreatment of Vulnipolicies will be covere semi-annually. Each member is trained on incident reporting policies the distriction. Persons Responsible: QIDP & Nursing	view of erable Adults es will be ng along with The upervisor re aware ents or VA done eporting and ent policy is a nd what is described. view of erable Adults d again new staff the VA and	Completion Date: 7/23/21	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		24G476	B. WING	;		C 06/08/2021	
	PROVIDER OR SUPPLIER	DD HOME		182	REET ADDRESS, CITY, STATE, ZIP CODE 20 EAST 39TH STREET BBING, MN 55746		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 155 W 155	CFR(s): 483.420(d) The facility must prevailed the investigated on observareview the agency investigating an allectient (C2) reviewed Findings include: C2's Individual abundated 5/13/21, indicated 5/13/	NT OF CLIENTS)(3) event further potential abuse ion is in progress. s not met as evidenced by: tion, interview and document failed to protect clients while egation of abuse for 1 of 1		155 155	Range Center will ensure the safety of the client by placing a alleged staff member on administrative leave during an investigation into any allegation abuse. The Director of Residential Services will monitor facility state on the sure any alleged staff member is placed on leave duri an investigation into any allegation of abuse. Persons Responsible: Director of Residential Services	n of aff ing	Completion Date: 7/9/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G476	B. WING			C 06/08/2021	
	PROVIDER OR SUPPLIER			S'	TREET ADDRESS, CITY, STATE, ZIP CODE 820 EAST 39TH STREET IIBBING, MN 55746	06/0	J8/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 155	Continued From pa	ige 6	w ·	W 155			
		a.m. the agency chief (CEO) was notified of the					
	let the director of reabout the allegation resources. The CEC surveyor had comp investigation. The CIDP but had n and had not investigated in terms of p investigation, typical followed and an inc The CEO stated sh	o.m. the CEO stated she had esidential services (DRS) known and had also notified human O stated she thought the eleted and concluded the CEO stated they had talked to not talked to the clients or staff gated the incident. The CEO erotecting C2 during an eally they made sure rights were elident report was complete. The thought where they mad a mought the investigation was or.					
	evidence the AP wa	aff schedule on 6/7/21 lacked as removed from the schedule allegation of abuse on 6/4/21					
W 331	The agency's abuse received. NURSING SERVIC CFR(s): 483.460(c)		w s	331			
		ovide clients with nursing nce with their needs.					
	Based on interview agency failed to ide	s not met as evidenced by: y and document review the entify a significant weight loss) reviewed for nursing					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		24G476	B. WING		C 06/08/2021	
	PROVIDER OR SUPPLIER	DD HOME		STREET ADDRESS, CITY, STATE, ZIF 1820 EAST 39TH STREET HIBBING, MN 55746		70072021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 331	services. Findings include: C2's Coordinated S 5/13/21, indicated a year and identified tremors/shaking, w issues and a need staff. Document titled Me 5/7/21, indicated C registered dietician information indicate (lbs) and identified assessment directe weight loss continu evidence of additio weight loss. During an observat approximately 2:00 wheel chair. C2 ha assisted by staff ar C2's Weight Recor weights: December 2020, 1 January 2021, 128 February 2021, 132 March 2021, 132 lk May 2021, 118 lbs. Range Center Syst assessments), con	Services Support Plan date a decline health over the past an increase in reight loss, gastro-intestinal for increased assistance from edical Health Information dated 2 had been assessed by the (RD) 12/17/19. The ed C2 weighed 135 pounds a 10 lb weight loss. The ed staff to refer to the RD if the ed. The record lacked nal RD assessments related to the increase of the edical received a shower earlier and appeared well groomed. In didentified the following seems Reviews (nursing appleted by licensed practical ntified the following: 0	W	Range Center, Inc., has ICF/ID Weight Tracking completed when a clie greater than a 5 lb. we a month. Nursing stat complete the form and required notifications. once completed, will be by the Residential Dire Nursing staff were ind trained on this form an utilize it. This form with completed for all Range clients residing in ICF I time there is a greater weight loss in a month Persons Responsible: QIDP & Nursing	g Form to be ent has eight loss in ff will d make the . The form, be reviewed ector. lividually and when to ill be ge Center homes each r than five lb.	Completion Date: 7/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G476	B. WING			C 06/08/2021	
NAME OF	PROVIDER OR SUPPLIER	240470		_	STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/0	08/2021
RANGE	CENTER ASPENWOO	DD HOME			1820 EAST 39TH STREET HIBBING, MN 55746		
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	12/19/20, weight bla 2/18/21, weight bla 2/18/21, weight bla During interview or stated she had just loss on Saturday (t LPN-A stated she consisted I need to have section." LPN-A fur trained a few mont with another nurse skipped over that sections. The clinic social seen in the clips of the clinic social seen in the clips. The clinic social seen in the clips. The clinic social seen in the clips. The clinic social seen in the clips of the clinic social seen in the clips. The clinic social seen in the clips of the clinic social seen in the clips. The clinic social seen in the clips of the clinic seen in the c	ank nk n 6/2/21, at 12:14 p.m. LPN-A found out about C2's weight wo days prior to the interview). completed the Range Center and said she filled them out or the chart. LPN-A stated, "I lave them fill out the weight ther stated when she was hs prior, she went on a visit and the other nurse had ection. nic social worker stated C2 had inic on 5/28/21, and said C2's cerns related to C2's weight cial worker stated C2 had lost ne and the physician was "very nat." 100 p.m. C2's guardian (G)-A d the annual review and the cell her how much weight C2 d she had gone to visit C2 and all new clothes because her		331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		24G476	B. WING		C 06/08/2021	
	PROVIDER OR SUPPLIER	DD HOME		STREET ADDRESS, CITY, STATE, ZIP CO 1820 EAST 39TH STREET HIBBING, MN 55746		10012021
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 331	information was co review. RN-A stated quarterly meetings. house weighed the supposed to transo stated it wasn't gett it. RN-A stated more On 6/7/21, at 5:14 (RD) confirmed she December of 2019 weight loss and stated she was not lose any more started her on a su stated the agency started.	information and said the mmunicated at the quarterly d she did not attend any of the RN-A stated the people in the clients and the nurses were tribe the information. She ting done and she had missed the training was needed. p.m. the registered dietician the had last seen C2 in the Rd stated C2 had a lot of the C2 was a Picky eater. The lat an "okay" weight but should and said the physician had pplement. The RD further should have let her know tinued to lose weight and said	W 3	31		



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed on June 25, 2021

Administrator Range Center Aspenwood Home 1820 East 39th Street Hibbing, MN 55746

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: C2Q411

Dear Administrator:

The above facility was surveyed on June 2, 2021 through June 8, 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.

Range Center Aspenwood Home

Page 2

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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 Susie Haben. 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

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

Range Center Aspenwood Home

Page 3

PRINTED: 06/25/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL [*] A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24G476	B. WING				C 08/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2021
RANGE	CENTER ASPENWOO	D HOME	1820 EAST 39TH STREET HIBBING, MN 55746				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	INITIAL COMMEN	гѕ	W 0	000			
W 124	completed at your finvestigation. Your compliance with 42 requirements for In Individuals with Intel HG476002C (MN73 be SUBSTANTIATE W124, W331. As a result of the indeficiencies were in W155. PROTECTION OF CFR(s): 483.420(a) The facility must en Therefore the facility parent (if the client of the client's medicand behavioral sta		W 1	124			
	Based on interview agency failed to not	s not met as evidenced by: y and document review the tify guardians of a significant 2 clients (C2) reviewed for					
	Findings include:						
		Services Support Plan date a decline health over the past an increase in					
L ABORATOR'	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITLE		(X6) DATE

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

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		TIPLE CONSTRUCTION ING		COMPLETED		
		24G476	B. WING		Of Of	C 5/08/2021
	PROVIDER OR SUPPLIER	D HOME		STREET ADDRESS, CITY, STATE, ZIP CO 1820 EAST 39TH STREET HIBBING, MN 55746		70072021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
W 124	tremors/shaking, wissues and a need staff. C2's Weight Record weights: December 2020, 13 January 2021, 128 February 2021, 130 March 2021, 132 lb May 2021, 118 lbs. A total of 16 lbs. ov During interview on p.m. C2's guardian visit C2 and had to her clothes were all the visit she had no COVID-19 pandem been notified of the	eight loss, gastro-intestinal for increased assistance from did identified the following 34 lbs. (pounds) lbs.	W 1	124		
W 149	individual homes. F C2's weight loss on 5/24/21. RN-A state assessments she v completed but did r information and sai communicated at the stated she had not meetings. STAFF TREATMEN CFR(s): 483.420(d) The facility must de policies and proced	RN-A stated she had identified her last visit to the house on ed when she signed off on the was signing that they were not actually review the d the information was ne quarterly review. RN-A attended any of the quarterly NT OF CLIENTS (1)	W 1	149		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C	
		24G476	B. WING _			08/2021
	PROVIDER OR SUPPLIER	DD HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1820 EAST 39TH STREET HIBBING, MN 55746		
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
W 149	Continued From pa	ge 2	W 14	9		
	Based on interview facility failed to imp reporting allegation	s not met as evidenced by: y and document review the lement their policy for s of abuse to the state agency it (C2) reviewed for abuse.				
	dated 5/13/21, indicabuse. The IAPP ic reported and traine	se prevention plan (IAPP) cated she was susceptible to lentified staff as mandated d biannually on vulnerable j. The plan directed staff to				
	guardian (G)-A state phone upset and consider qualified intellectual (QIDP) "got into it as G-A stated she had upset every night the asked C2 to put the and ask the QIDP to G-A stated the QID telling her she could room and the cup he stated C2 just want and said, "she was feel like she is bein believed the QIDP through her stuff. Gon, I'm convinced con help." G-A stated the properties of	ed C2 had called her on the rying. G-A stated C2 and the I disabilities professional about her (C2)'s favorite cup. I received a call from C2, his week. G-A stated she is phone in her lap and go out to help her get a cup of water. P was talking down to C2, dn't have a cup of water in her had to stay in the kitchen. G-A and the dealer of water in her room crying so hard." G-A said "I g abused." G-A stated she went into C2's room and went G-A stated "something is going of it." "She's crying out for the QIDP pushed C2's buttons as which ones to push."				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG	` ´COM	COMPLETED	
		24G476	B. WING			08/2021	
	PROVIDER OR SUPPLIER	DD HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1820 EAST 39TH STREET HIBBING, MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 149	On 6/4/21, at 10:58 engineering officer allegation of abuse On 6/7/21, at 1:26 let the director of reabout the allegation resources. The CE the allegation to the was why the survey CEO stated typicall was received she wimmediately. The agency's abus provided. STAFF TREATMENT CFR(s): 483.420(d) The facility must ermistreatment, neglicinjuries of unknown immediately to the officials in accordance stablished proced. This STANDARD is Based on interview facility failed to report and survey and the stablished to report and the stablished proced.	a.m. the agency chief (CEO) was notified of the CEO) was notified of the common the CEO stated she had esidential services (DRS) known and had also notified human O stated she had not reported as SA because she thought that wor was at the agency. The yould report it to the SA expected but not work of the CEO of the CEO of the common that all allegations of eact or abuse, as well as a source, are reported administrator or to other note with State law through the common that allegation of abuse to common that allegation of abuse to common the common that allegation that all alleg	W 1				
	dated 5/13/21, indi	se prevention plan (IAPP) cated she was susceptible to staff to report allegations of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G476	B. WING	B. WING		C 06/08/2021	
	PROVIDER OR SUPPLIE		•	STREET ADDRESS, CIT 1820 EAST 39TH STR HIBBING, MN 5574	TY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 153	abuse. During interview of guardian (G)-A staphone upset and qualified intellectu (QIDP) "got into it G-A stated she had upset every night asked C2 to put the land ask the QIDF G-A stated the QIDF G-A stated the QIDF through her she couroom and the cup stated C2 just wall and said, "she was feel like she is be believed the QIDF through her stuff. on, I'm convinced help." G-A stated and said "she known on 6/4/21, at 10:5 engineering office allegation of abuse on 6/7/21, at 1:26 let the director of about the allegation to the allegation to the was why the surven CEO stated typical was received she	on 6/3/21, at 6:45 p.m. C2's ated C2 had called her on the crying. G-A stated C2 and the lad disabilities professional about her (C2)'s favorite cup. ad received a call from C2, this week. G-A stated she he phone in her lap and go out to help her get a cup of water. DP was talking down to C2, aldn't have a cup of water in her had to stay in the kitchen. G-A anted a cup of water in her room as crying so hard." G-A said "I ing abused." G-A stated she of went into C2's room and went G-A stated "something is going of it." "She's crying out for the QIDP pushed C2's buttons ows which ones to push."	W	53			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		24G476	B. WING				C 06/08/2021	
NAME OF PROVIDER				STREET A	ADDRESS, CITY, STATE, ZIP COI ST 39TH STREET G, MN 55746	DE	1 00/0	00/2021
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
W 155 STAFF CFR(s The fa while to the second secon	cility must price investigat TANDARD is lon observation and consideration and consi	NT OF CLIENTS	W 1					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G476	B. WING			C / 08/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1820 EAST 39TH STREET HIBBING, MN 55746		06/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 155	Continued From pa		W 1	55			
		a.m. the agency chief (CEO) was notified of the					
	let the director of reabout the allegation resources. The CEO surveyor had comp investigation. The C the QIDP but had n and had not investigated in terms of p investigation, typica followed and an inc The CEO stated sh mistake was they the done by the surveyor						
	evidence the AP wa	aff schedule on 6/7/21 lacked as removed from the schedule allegation of abuse on 6/4/21					
W 331	The agency's abuse received. NURSING SERVIC CFR(s): 483.460(c)		W 3:	31			
		ovide clients with nursing nce with their needs.					
	Based on interview agency failed to ide	s not met as evidenced by: and document review the ntify a significant weight loss reviewed for nursing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		24G476	B. WING_		06	5/08/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1820 EAST 39TH STREET HIBBING, MN 55746	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 331	5/13/21, indicated year and identified tremors/shaking, wissues and a need staff. Document titled Mr 5/7/21, indicated Cregistered dieticiar information indicat (lbs) and identified assessment direct weight loss continuevidence of additional weight loss. During an observation approximately 2:00 wheel chair. C2 has assisted by staff and C2's Weight Recommendation weights: December 2020, 1 January 2021, 128 February 2021, 13 March 2021, 132 II May 2021, 118 Ibs Range Center Sys	Services Support Plan date a decline health over the past an increase in veight loss, gastro-intestinal for increased assistance from edical Health Information dated 2 had been assessed by the a (RD) 12/17/19. The ed C2 weighed 135 pounds a 10 lb weight loss. The ed staff to refer to the RD if the ed Staff to refer to the RD if the ed. The record lacked anal RD assessments related to the edition of C2 on 6/2/21, at 0 p.m. C2 was seated in her directived a shower earlier and appeared well groomed. To didentified the following 34 lbs. Ibs. Ibs. Ibs. Ibs. Ibs. Ibs. Ibs. Ibs. Ibs. Items Reviews (nursing	W 33	31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		24G476	B. WING _			08/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1820 EAST 39TH STREET HIBBING, MN 55746	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
W 331	stated she had justoss on Saturday (CLPN-A stated she Systems Reviews and made copies for realized I need to I section." LPN-A futrained a few montwith another nurse skipped over that stated she attended agency could not the had lost. G-A stated she attended agency could not the had lost. G-A stated she had to buy her clothes were too book on 6/4/21, at 9:47 stated she only spindividual homes and did not docum RN-A stated her roto be available if the stated she had idelast visit to the hour stated she had idelast visit to t	lank ank ank ank ank ank ank ank ank ank		1		

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		24G476	B. WING		0.00	C / 08/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1820 EAST 39TH STREET HIBBING, MN 55746		706/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 331	information was correview. RN-A stated quarterly meetings. house weighed the supposed to transc stated it wasn't gett it. RN-A stated mor On 6/7/21, at 5:14 p (RD) confirmed she December of 2019, weight loss and sta RD stated she was not lose any more a started her on a supstated the agency stated.	information and said the immunicated at the quarterly dishe did not attend any of the RN-A stated the people in the clients and the nurses were ribe the information. She ing done and she had missed e training was needed. o.m. the registered dietician had last seen C2 in The Rd stated C2 had a lot of ted C2 was a Picky eater. The at an "okay" weight but should and said the physician had oplement. The RD further should have let her know tinued to lose weight and said	W 3	31		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
01629	B. WING		06/0	8/2021
	ADDRESS, CITY, ST	,	•	
RANGE CENTER ASPENWOOD HOME	AST 39TH STRE G, MN 55746	EET		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
5 000 Initial Comments	5 000			
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 6/2/21 - 6/8/21, a surveyor of this Department's staff visited the above provider and the following correction orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to: Minnesota Department of Health Health Regulation Division Licensing and Certification Program 3333 West Division St, Suite 212	ł d			

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

TITLE (X6) DATE Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			71. BOILDING.		С		
		01629	B. WING		1	8/2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
RANGE (CENTER ASPENWOO	DD HOME	T 39TH STR MN 55746	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
5 000	Continued From pa	ige 1	5 000				
	St Cloud, MN 56301						
	or email Susie Haben at susie.haben@state.mn.us						
5 380	MN Rule 4665.330 SERVICES.	0 PURPOSE OF HEALTH	5 380				
	optimal general lev	all be utilized to maintain an el of health and to maximize sability, and promote optimal ch resident.					
	This MN Requirement is not met as evidenced by: Based on interview and document review the agency failed to identify a significant weight loss for 1 of 2 client (C1) reviewed for nursing services.						
	Findings include:						
	5/13/21, indicated a year and identified tremors/shaking, w	Services Support Plan date a decline health over the past an increase in eight loss, gastro-intestinal for increased assistance from					
	5/7/21, indicated Cregistered dietician information indicate (lbs) and identified assessment directe weight loss continu	edical Health Information dated 2 had been assessed by the (RD) 12/17/19. The ed C2 weighed 135 pounds a 10 lb weight loss. The ed staff to refer to the RD if the ed. The record lacked nal RD assessments related to					

Minnesota Department of Health

STATE FORM 6899 C2Q411 If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		01629	B. WING		06/0) 8/2021
	PROVIDER OR SUPPLIER	STREET AD 1820 EAS	DRESS, CITY, S T 39TH STR MN 55746	STATE, ZIP CODE EET	,	
(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)	ILD BE	(X5) COMPLETE DATE
5 380	Continued From pa	age 2	5 380			
	approximately 2:00 wheel chair. C2 had assisted by staff and C2's Weight Recorn weights: December 2020, 13 January 2021, 128 February 2021, 132 lb May 2021, 118 lbs. Range Center Systassessments), com	lbs. D lb				
	stated she had just loss on Saturday (t LPN-A stated she of Systems Reviews a and made copies for realized I need to his section." LPN-A fur trained a few month with another nurse skipped over that sexipped over that sexipped seen in the cliquardians had concloss. The clinic socioloss.	nic social worker stated C2 had inic on 5/28/21, and said C2's cerns related to C2's weight ial worker stated C2 had lost ne and the physician was "very				

Minnesota Department of Health

STATE FORM 6899 C2Q411 If continuation sheet 3 of 7

			PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				71. BOILBING.			С	
		01629)	B. WING		l l	08/2021	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
RANGE	CENTER ASPENWOO	D HOME		T 39TH STR MN 55746	EET			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
5 380	Continued From page 3			5 380				
	At approximately 2: stated she attended agency could not to had lost. G-A stated she had to buy her clothes were too big. On 6/4/21, at 9:47 a stated she only special individual homes at and did not docume RN-A stated her rol to be available if the stated she had ider last visit to the house when she signed or signing that they we actually review the information was conview. RN-A stated quarterly meetings house weighed the supposed to transcribe stated it wasn't gett it. RN-A stated more On 6/7/21, at 5:14 p (RD) confirmed she December of 2019 weight loss and started she was not lose any more a started her on a supposed to the supposed to the supposed to transcribe stated it wasn't gett it. RN-A stated more on 6/7/21, at 5:14 p (RD) confirmed she stated the same started her on a supposed to the suppose	d the annual ell her how not she had go all new cloth go. a.m. register ent one hour not stated she ent in the mode to the ent in the mode was not do to the LPN's had not ellents and ribe the information mmunicated dishe did not RN-A state clients and ribe the information ing done and the training words. The Rd stated C2 was at an "okay and said the pplement. To should have tinued to loss the colors."	review and the nuch weight C2 one to visit C2 and hes because her red nurse (RN)-A per week at the le was a consultant edical record. Oing the work but I questions. RN-A weight loss on her 1. RN-A stated sessments she was ed but did not and said the dat the quarterly at attend any of the d the people in the the nurses were ormation. She led she had missed as needed. Instead C2 had a lot of a Picky eater. The weight but should physician had he RD further let her know					
	TIME PERIOD FOR	R CORREC	TION: Twenty-one					

Minnesota Department of Health

STATE FORM 6899 C2Q411 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		01629	B. WING			C 08/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
RANGE	CENTER ASPENWOO	D HOME	ST 39TH STRI	EET			
	0.0000000000000000000000000000000000000		i, MN 55746	DDOVIDEDIO DI ANI OF COD	PEGTION		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
5 380	Continued From pa	ge 4	5 380				
	(21) days.						
5 815	MN Statute 626.557	7 Subd. 3. VA Timing of report.	5 815				
	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 sindividual that occu unless: (1) the individual wa another facility and reason to believe the maltreated in the properties of clause (4). (b) A person not recoprovisions of this sereport as described (c) Nothing in this sknown or suspected reporter knows or hereport has been maded). Nothing in this sereporter from also reason to believe the 626.5572, subdivisi (5), occurred must	ne vulnerable adult was revious facility; or ws or has reason to believe a vulnerable adult as 26.5572, subdivision 21, quired to report under the rection may voluntarily					

Minnesota Department of Health

STATE FORM 6899 C2Q411 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED			
	01629	B. WING		06/0	8/2021		
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE				
RANGE CENTER ASPENWOOD HOME 1820 EAST 39TH STREET HIBBING, MN 55746							
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
believes that an inversible will determine or shore reported error was recriteria under section paragraph (c), claus may provide to the lead agency in event meets the critical subdivision 17, parallead agency shall comaking an initial dissolution 9c. This MN Requirements by: Based on interview a facility failed to report the state agency (SA reviewed for abuse. Findings include: C2's Individual abust dated 5/13/21, indicated 5/13/21, indicated abuse. During interview on guardian (G)-A stated phone upset and cryqualified intellectual (QIDP) "got into it at G-A stated she had upset every night thi asked C2 to put the and ask the QIDP to G-A stated the QIDP	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 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 report an allegation of abuse to the state agency (SA) for 1 of 1 client (C2) reviewed for abuse. Findings include: C2's Individual abuse prevention plan (IAPP) dated 5/13/21, indicated she was susceptible to abuse and directed staff to report allegations of						

Minnesota Department of Health

STATE FORM 6899 C2Q411 If continuation sheet 6 of 7

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
				A. BUILDING:					
		01629		B. WING)8/2021		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
RANGE CENTER ASPENWOOD HOME 1820 EAST 39TH STREET HIBBING, MN 55746									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE				
5 815	Continued From parand said, "she was feel like she is bein believed the QIDP of through her stuff. Gon, I'm convinced of help." G-A stated the and said "she known On 6/4/21, at 10:58 engineering officer allegation of abuse. On 6/7/21, at 1:26 plet the director of reabout the allegation resources. The CE of the allegation to the was why the survey CEO stated typicall was received she with the agency's abuse received. TIME PERIOD FOR (21) days.	crying so hard. g abused." G-A went into C2's r-A stated "som fit." "She's cryice QIDP pushed so which ones to a.m. the agend (CEO) was noticed. The control of the central service and had also read the central service and had also read the agency was at the act of the central service and had also read the central service and had also read the central service and had also read the act of the central service and had also read the central service and had also read the central service and the central service	a stated she coom and went ething is going ng out for d C2's buttons o push." by chief ified of the tated she had es (DRS) know notified human ad not reported he thought that gency. The gation of abuse o the SA. quested but not	5 815					

6899

Minnesota Department of Health STATE FORM