DEPARTMENT OF HEALTH

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G476	A. BUILDING _____ B. WING _____	C 06/08/2021

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) COMPLETION DATE
W 000	INITIAL COMMENTS On 6/2/21 - 6/8/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was NOT IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. HG476002C (MN73321, MN73049) was found to be SUBSTANTIATED with deficiencies cited at W124, W331. As a result of the investigation additional deficiencies were identified at W149, W153 and W155.	W 000	see attached POC doc Preparation and execution of 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 the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	approved 8/10/21
W 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and document review the agency failed to notify guardians of a significant weight loss for 1 of 2 clients (C2) reviewed for client rights. Findings include: C2's Coordinated Services Support Plan date 5/13/21, indicated a decline health over the past year and identified an increase in	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laurie Clark	Residential Director	7-9-21

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

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W 124	Continued From page 1 tremors/shaking, weight loss, gastro-intestinal issues and a need for increased assistance from staff. C2's Weight Record identified the following weights: December 2020, 134 lbs. (pounds) January 2021, 128 lbs. February 2021, 130 lbs. March 2021, 132 lbs. May 2021, 118 lbs. A total of 16 lbs. over a five month period. During interview on 6/2/21, at approximately 2:00 p.m. C2's guardian (G)-A stated she had gone to visit C2 and had to buy her new clothes because her clothes were all too big. G-A stated prior to the visit she had not seen C2 since prior to the COVID-19 pandemic. G-A stated she had not been notified of the ongoing weight loss. On 6/4/21, at 9:47 a.m. registered nurse (RN)-A stated she only spent one hour per week at the individual homes. RN-A stated she had identified C2's weight loss on her last visit to the house on 5/24/21. RN-A stated when she signed off on the assessments she was signing that they were completed but did not actually review the information and said the information was communicated at the quarterly review. RN-A stated she had not attended any of the quarterly meetings.	W 124	Range Center, Inc., has created an ICF/ID Weight Tracking Form to be completed when a client has greater than a 5 lb. weight loss in a month. Nursing staff will complete the form and make the required notifications. The form, once completed, will be reviewed by the Residential Director. Nursing staff were individually trained on this form and when to utilize it. This form will be completed for all Range Center clients residing in ICF homes each time there is a greater than five lb. weight loss in a month. **Persons Responsible:** QIDP & Nursing	**Completion Date: 7/10/21**
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	W 149	Range Center, Inc., already has written policies and procedures in place for the reporting of incidents and maltreatment of vulnerable adults that includes mistreatment, neglect or abuse of clients. Please see attached policies.	

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W 149	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to implement their policy for reporting allegations 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. The IAPP identified staff as mandated reported and trained biannually on vulnerable adult (VA) reporting. The plan directed staff to report any abuse. 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 help." G-A stated the QIDP pushed C2's buttons and said "she knows which ones to push."	W 149	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 needs to be reported is described. The *Reporting and Review of Maltreatment of Vulnerable Adults* policies will be covered again semi-annually. Each new staff member is trained on the VA and incident reporting policies as they are hired. **Persons Responsible:** QIDP & Nursing **Completion Date:** **7/23/21**	

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W 149	Continued From page 3 On 6/4/21, at 10:58 a.m. the agency chief engineering officer (CEO) was notified of the allegation of abuse. On 6/7/21, at 1:26 p.m. the CEO stated she had let the director of residential services (DRS) know about the allegation and had also notified human resources. The CEO stated she had not reported the allegation to the SA because she thought that was why the surveyor was at the agency. The CEO stated typically when an allegation of abuse was received she would report it to the SA immediately. The agency's abuse policy was requested but not provided.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. 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. 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	W 153	Range Center, Inc., already has written policies and procedures in place for the reporting of incidents and maltreatment of vulnerable adults that includes mistreatment, neglect or abuse of clients. Please see attached policies.	

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W 153	Continued From page 4 abuse. 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 help." G-A stated the QIDP pushed C2's buttons and said "she knows which ones to push." On 6/4/21, at 10:58 a.m. the agency chief engineering officer (CEO) was notified of the allegation of abuse. On 6/7/21, at 1:26 p.m. the CEO stated she had let the director of residential services (DRS) know about the allegation and had also notified human resources. The CEO stated she had not reported the allegation to the SA because she thought that was why the surveyor was at the agency. The CEO stated typically when an allegation of abuse was received she would report it to the SA. The agency's abuse policy was requested but not received.	W 153	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 needs to be reported is described. The *Reporting and Review of Maltreatment of Vulnerable Adults* policies will be covered again semi-annually. Each new staff member is trained on the VA and incident reporting policies as they are hired. **Persons Responsible:** QIDP & Nursing	**Completion Date:** **7/23/21**

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W 155	Continued From page 5	W 155		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on observation, interview and document review the agency failed to protect clients while investigating an allegation of abuse for 1 of 1 client (C2) reviewed for protections. Findings include: C2's Individual abuse prevention plan (IAPP) dated 5/13/21, indicated she was susceptible to abuse. 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 help." G-A stated the QIDP pushed C2's buttons and said "she knows which ones to push."	W 155	Range Center will ensure the safety of the client by placing any alleged staff member on administrative leave during an investigation into any allegation of abuse. The Director of Residential Services will monitor facility staff to ensure any alleged staff member is placed on leave during an investigation into any allegation of abuse. **Persons Responsible:** Director of Residential Services	**Completion Date: 7/9/21**

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W 155	Continued From page 6 On 6/4/21, at 10:58 a.m. the agency chief engineering officer (CEO) was notified of the allegation of abuse. On 6/7/21, at 1:26 p.m. the CEO stated she had let the director of residential services (DRS) know about the allegation and had also notified human resources. The CEO stated she thought the surveyor had completed and concluded the investigation. The CEO stated they had talked to the QIDP but had not talked to the clients or staff and had not investigated the incident. The CEO stated in terms of protecting C2 during an investigation, typically they made sure rights were followed and an incident report was complete. The CEO stated she thought where they mad a mistake was they thought the investigation was done by the surveyor. Review of facility staff schedule on 6/7/21 lacked evidence the AP was removed from the schedule following report of allegation of abuse on 6/4/21 at 10:58am. The agency's abuse policy was requested but not received.	W 155		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and document review the agency failed to identify a significant weight loss for 1 of 2 client (C1) reviewed for nursing	W 331		

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W 331	Continued From page 7 services. Findings include: C2's Coordinated Services Support Plan date 5/13/21, indicated a decline health over the past year and identified an increase in tremors/shaking, weight loss, gastro-intestinal issues and a need for increased assistance from staff. Document titled Medical Health Information dated 5/7/21, indicated C2 had been assessed by the registered dietician (RD) 12/17/19. The information indicated C2 weighed 135 pounds (lbs) and identified a 10 lb weight loss. The assessment directed staff to refer to the RD if the weight loss continued. The record lacked evidence of additional RD assessments related to weight loss. During an observation of C2 on 6/2/21, at approximately 2:00 p.m. C2 was seated in her wheel chair. C2 had received a shower earlier assisted by staff and appeared well groomed. C2's Weight Record identified the following weights: December 2020, 134 lbs. January 2021, 128 lbs. February 2021, 130 lbs. March 2021, 132 lbs. May 2021, 118 lbs. Range Center Systems Reviews (nursing assessments), completed by licensed practical nurse (LPN)-A, identified the following: 5/30/20, weight 150 9/28/20, weight 137	W 331	Range Center, Inc., has created an ICF/ID Weight Tracking Form to be completed when a client has greater than a 5 lb. weight loss in a month. Nursing staff will complete the form and make the required notifications. The form, once completed, will be reviewed by the Residential Director. Nursing staff were individually trained on this form and when to utilize it. This form will be completed for all Range Center clients residing in ICF homes each time there is a greater than five lb. weight loss in a month. **Persons Responsible:** QIDP & Nursing	**Completion Date:** **7/10/21**

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W 331	Continued From page 8 12/19/20, weight blank 2/18/21, weight blank During interview on 6/2/21, at 12:14 p.m. LPN-A stated she had just found out about C2's weight loss on Saturday (two days prior to the interview). LPN-A stated she completed the Range Center Systems Reviews and said she filled them out and made copies for the chart. LPN-A stated, "I realized I need to have them fill out the weight section." LPN-A further stated when she was trained a few months prior, she went on a visit with another nurse and the other nurse had skipped over that section. At 12:18 p.m. a clinic social worker stated C2 had been seen in the clinic on 5/28/21, and said C2's guardians had concerns related to C2's weight loss. The clinic social worker stated C2 had lost 17 lbs in a short time and the physician was "very concerned about that." At approximately 2:00 p.m. C2's guardian (G)-A stated she attended the annual review and the agency could not tell her how much weight C2 had lost. G-A stated she had gone to visit C2 and she had to buy her all new clothes because her clothes were too big. On 6/4/21, at 9:47 a.m. registered nurse (RN)-A stated she only spent one hour per week at the individual homes and stated she was a consultant and did not document in the medical record. RN-A stated her role was not doing the work but to be available if the LPN's had questions. RN-A stated she had identified C2's weight loss on her last visit to the house on 5/24/21. RN-A stated when she signed off on the assessments she was signing that they were completed but did not	W 331		

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W 331	Continued From page 9 actually review the information and said the information was communicated at the quarterly review. RN-A stated she did not attend any of the quarterly meetings. RN-A stated the people in the house weighed the clients and the nurses were supposed to transcribe the information. She stated it wasn't getting done and she had missed it. RN-A stated more training was needed. On 6/7/21, at 5:14 p.m. the registered dietician (RD) confirmed she had last seen C2 in December of 2019. The Rd stated C2 had a lot of weight loss and stated C2 was a Picky eater. The RD stated she was at an "okay" weight but should not lose any more and said the physician had started her on a supplement. The RD further stated the agency should have let her know sooner that C2 continued to lose weight and said no one had let her know.	W 331		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G476	A. BUILDING _____ B. WING _____	C 06/08/2021

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) COMPLETION DATE
W 000	INITIAL COMMENTS On 6/2/21 - 6/8/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was NOT IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. HG476002C (MN73321, MN73049) was found to be SUBSTANTIATED with deficiencies cited at W124, W331. As a result of the investigation additional deficiencies were identified at W149, W153 and W155.	W 000		
W 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and document review the agency failed to notify guardians of a significant weight loss for 1 of 2 clients (C2) reviewed for client rights. Findings include: C2's Coordinated Services Support Plan date 5/13/21, indicated a decline health over the past year and identified an increase in	W 124		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G476	A. BUILDING _____ B. WING _____	C 06/08/2021

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) COMPLETION DATE
W 124	Continued From page 1 tremors/shaking, weight loss, gastro-intestinal issues and a need for increased assistance from staff. C2's Weight Record identified the following weights: December 2020, 134 lbs. (pounds) January 2021, 128 lbs. February 2021, 130 lbs. March 2021, 132 lbs. May 2021, 118 lbs. A total of 16 lbs. over a five month period. During interview on 6/2/21, at approximately 2:00 p.m. C2's guardian (G)-A stated she had gone to visit C2 and had to buy her new clothes because her clothes were all too big. G-A stated prior to the visit she had not seen C2 since prior to the COVID-19 pandemic. G-A stated she had not been notified of the ongoing weight loss. On 6/4/21, at 9:47 a.m. registered nurse (RN)-A stated she only spent one hour per week at the individual homes. RN-A stated she had identified C2's weight loss on her last visit to the house on 5/24/21. RN-A stated when she signed off on the assessments she was signing that they were completed but did not actually review the information and said the information was communicated at the quarterly review. RN-A stated she had not attended any of the quarterly meetings.	W 124		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	W 149		

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W 149	Continued From page 2	W 149		

This STANDARD is not met as evidenced by:
Based on interview and document review the facility failed to implement their policy for reporting allegations 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. The IAPP identified staff as mandated reported and trained biannually on vulnerable adult (VA) reporting. The plan directed staff to report any abuse.

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 help." G-A stated the QIDP pushed C2's buttons and said "she knows which ones to push."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G476	A. BUILDING _____ B. WING _____	C 06/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANGE CENTER ASPENWOOD HOME	**1820 EAST 39TH STREET HIBBING, MN 55746**

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W 149	Continued From page 3 On 6/4/21, at 10:58 a.m. the agency chief engineering officer (CEO) was notified of the allegation of abuse. On 6/7/21, at 1:26 p.m. the CEO stated she had let the director of residential services (DRS) know about the allegation and had also notified human resources. The CEO stated she had not reported the allegation to the SA because she thought that was why the surveyor was at the agency. The CEO stated typically when an allegation of abuse was received she would report it to the SA immediately. The agency's abuse policy was requested but not provided.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. 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. 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	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G476	A. BUILDING _____ B. WING _____	C 06/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANGE CENTER ASPENWOOD HOME	**1820 EAST 39TH STREET HIBBING, MN 55746**

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W 153	Continued From page 4 abuse. 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 help." G-A stated the QIDP pushed C2's buttons and said "she knows which ones to push." On 6/4/21, at 10:58 a.m. the agency chief engineering officer (CEO) was notified of the allegation of abuse. On 6/7/21, at 1:26 p.m. the CEO stated she had let the director of residential services (DRS) know about the allegation and had also notified human resources. The CEO stated she had not reported the allegation to the SA because she thought that was why the surveyor was at the agency. The CEO stated typically when an allegation of abuse was received she would report it to the SA. The agency's abuse policy was requested but not received.	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G476	A. BUILDING _____ B. WING _____	C 06/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANGE CENTER ASPENWOOD HOME	**1820 EAST 39TH STREET HIBBING, MN 55746**

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W 155	Continued From page 5	W 155		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on observation, interview and document review the agency failed to protect clients while investigating an allegation of abuse for 1 of 1 client (C2) reviewed for protections. Findings include: C2's Individual abuse prevention plan (IAPP) dated 5/13/21, indicated she was susceptible to abuse. 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 help." G-A stated the QIDP pushed C2's buttons and said "she knows which ones to push."	W 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G476	A. BUILDING _____ B. WING _____	C 06/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANGE CENTER ASPENWOOD HOME	**1820 EAST 39TH STREET HIBBING, MN 55746**

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W 155	Continued From page 6 On 6/4/21, at 10:58 a.m. the agency chief engineering officer (CEO) was notified of the allegation of abuse. On 6/7/21, at 1:26 p.m. the CEO stated she had let the director of residential services (DRS) know about the allegation and had also notified human resources. The CEO stated she thought the surveyor had completed and concluded the investigation. The CEO stated they had talked to the QIDP but had not talked to the clients or staff and had not investigated the incident. The CEO stated in terms of protecting C2 during an investigation, typically they made sure rights were followed and an incident report was complete. The CEO stated she thought where they mad a mistake was they thought the investigation was done by the surveyor. Review of facility staff schedule on 6/7/21 lacked evidence the AP was removed from the schedule following report of allegation of abuse on 6/4/21 at 10:58am. The agency's abuse policy was requested but not received.	W 155		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and document review the agency failed to identify a significant weight loss for 1 of 2 client (C1) reviewed for nursing	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G476	A. BUILDING _____ B. WING _____	C 06/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANGE CENTER ASPENWOOD HOME	**1820 EAST 39TH STREET HIBBING, MN 55746**

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W 331	Continued From page 7	W 331		

services.

Findings include:

C2's Coordinated Services Support Plan date 5/13/21, indicated a decline health over the past year and identified an increase in tremors/shaking, weight loss, gastro-intestinal issues and a need for increased assistance from staff.

Document titled Medical Health Information dated 5/7/21, indicated C2 had been assessed by the registered dietician (RD) 12/17/19. The information indicated C2 weighed 135 pounds (lbs) and identified a 10 lb weight loss. The assessment directed staff to refer to the RD if the weight loss continued. The record lacked evidence of additional RD assessments related to weight loss.

During an observation of C2 on 6/2/21, at approximately 2:00 p.m. C2 was seated in her wheel chair. C2 had received a shower earlier assisted by staff and appeared well groomed.

C2's Weight Record identified the following weights:
December 2020, 134 lbs.
January 2021, 128 lbs.
February 2021, 130 lbs.
March 2021, 132 lbs.
May 2021, 118 lbs.

Range Center Systems Reviews (nursing assessments), completed by licensed practical nurse (LPN)-A, identified the following:
5/30/20, weight 150
9/28/20, weight 137

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RANGE CENTER ASPENWOOD HOME	**1820 EAST 39TH STREET HIBBING, MN 55746**

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W 331	Continued From page 8 12/19/20, weight blank 2/18/21, weight blank During interview on 6/2/21, at 12:14 p.m. LPN-A stated she had just found out about C2's weight loss on Saturday (two days prior to the interview). LPN-A stated she completed the Range Center Systems Reviews and said she filled them out and made copies for the chart. LPN-A stated, "I realized I need to have them fill out the weight section." LPN-A further stated when she was trained a few months prior, she went on a visit with another nurse and the other nurse had skipped over that section. At 12:18 p.m. a clinic social worker stated C2 had been seen in the clinic on 5/28/21, and said C2's guardians had concerns related to C2's weight loss. The clinic social worker stated C2 had lost 17 lbs in a short time and the physician was "very concerned about that." At approximately 2:00 p.m. C2's guardian (G)-A stated she attended the annual review and the agency could not tell her how much weight C2 had lost. G-A stated she had gone to visit C2 and she had to buy her all new clothes because her clothes were too big. On 6/4/21, at 9:47 a.m. registered nurse (RN)-A stated she only spent one hour per week at the individual homes and stated she was a consultant and did not document in the medical record. RN-A stated her role was not doing the work but to be available if the LPN's had questions. RN-A stated she had identified C2's weight loss on her last visit to the house on 5/24/21. RN-A stated when she signed off on the assessments she was signing that they were completed but did not	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 331	Continued From page 9 actually review the information and said the information was communicated at the quarterly review. RN-A stated she did not attend any of the quarterly meetings. RN-A stated the people in the house weighed the clients and the nurses were supposed to transcribe the information. She stated it wasn't getting done and she had missed it. RN-A stated more training was needed. On 6/7/21, at 5:14 p.m. the registered dietician (RD) confirmed she had last seen C2 in December of 2019. The Rd stated C2 had a lot of weight loss and stated C2 was a Picky eater. The RD stated she was at an "okay" weight but should not lose any more and said the physician had started her on a supplement. The RD further stated the agency should have let her know sooner that C2 continued to lose weight and said no one had let her know.	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01629	A. BUILDING: _____ B. WING _____	C 06/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANGE CENTER ASPENWOOD HOME	**1820 EAST 39TH STREET HIBBING, MN 55746**

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 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	5 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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5 000	Continued From page 1 St Cloud, MN 56301 or email Susie Haben at susie.haben@state.mn.us	5 000		
5 380	MN Rule 4665.3300 PURPOSE OF HEALTH SERVICES. Health services shall be utilized to maintain an optimal general level of health and to maximize function, prevent disability, and promote optimal development of each resident. This MN Requirement is not met as evidenced by: Based on interview and document review the agency failed to identify a significant weight loss for 1 of 2 client (C1) reviewed for nursing services. Findings include: C2's Coordinated Services Support Plan date 5/13/21, indicated a decline health over the past year and identified an increase in tremors/shaking, weight loss, gastro-intestinal issues and a need for increased assistance from staff. Document titled Medical Health Information dated 5/7/21, indicated C2 had been assessed by the registered dietician (RD) 12/17/19. The information indicated C2 weighed 135 pounds (lbs) and identified a 10 lb weight loss. The assessment directed staff to refer to the RD if the weight loss continued. The record lacked evidence of additional RD assessments related to weight loss.	5 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RANGE CENTER ASPENWOOD HOME	1820 EAST 39TH STREET HIBBING, MN 55746

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5 380	Continued From page 2 During an observation of C2 on 6/2/21, at approximately 2:00 p.m. C2 was seated in her wheel chair. C2 had received a shower earlier assisted by staff and appeared well groomed. C2's Weight Record identified the following weights: December 2020, 134 lbs. January 2021, 128 lbs. February 2021, 130 lbs. March 2021, 132 lbs. May 2021, 118 lbs. Range Center Systems Reviews (nursing assessments), completed by licensed practical nurse (LPN)-A, identified the following: 5/30/20, weight 150 9/28/20, weight 137 12/19/20, weight blank 2/18/21, weight blank During interview on 6/2/21, at 12:14 p.m. LPN-A stated she had just found out about C2's weight loss on Saturday (two days prior to the interview). LPN-A stated she completed the Range Center Systems Reviews and said she filled them out and made copies for the chart. LPN-A stated, "I realized I need to have them fill out the weight section." LPN-A further stated when she was trained a few months prior, she went on a visit with another nurse and the other nurse had skipped over that section. At 12:18 p.m. a clinic social worker stated C2 had been seen in the clinic on 5/28/21, and said C2's guardians had concerns related to C2's weight loss. The clinic social worker stated C2 had lost 17 lbs in a short time and the physician was "very concerned about that."	5 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01629	A. BUILDING: _____ B. WING _____	C 06/08/2021

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5 380	Continued From page 3 At approximately 2:00 p.m. C2's guardian (G)-A stated she attended the annual review and the agency could not tell her how much weight C2 had lost. G-A stated she had gone to visit C2 and she had to buy her all new clothes because her clothes were too big. On 6/4/21, at 9:47 a.m. registered nurse (RN)-A stated she only spent one hour per week at the individual homes and stated she was a consultant and did not document in the medical record. RN-A stated her role was not doing the work but to be available if the LPN's had questions. RN-A stated she had identified C2's weight loss on her last visit to the house on 5/24/21. RN-A stated when she signed off on the assessments she was signing that they were completed but did not actually review the information and said the information was communicated at the quarterly review. RN-A stated she did not attend any of the quarterly meetings. RN-A stated the people in the house weighed the clients and the nurses were supposed to transcribe the information. She stated it wasn't getting done and she had missed it. RN-A stated more training was needed. On 6/7/21, at 5:14 p.m. the registered dietician (RD) confirmed she had last seen C2 in December of 2019. The Rd stated C2 had a lot of weight loss and stated C2 was a Picky eater. The RD stated she was at an "okay" weight but should not lose any more and said the physician had started her on a supplement. The RD further stated the agency should have let her know sooner that C2 continued to lose weight and said no one had let her know. TIME PERIOD FOR CORRECTION: Twenty-one	5 380		

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5 380	Continued From page 4 (21) days.	5 380		
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the 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	5 815		

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5 815	Continued From page 5	5 815		

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 abuse.

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

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5 815	Continued From page 6 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 help." G-A stated the QIDP pushed C2's buttons and said "she knows which ones to push." On 6/4/21, at 10:58 a.m. the agency chief engineering officer (CEO) was notified of the allegation of abuse. On 6/7/21, at 1:26 p.m. the CEO stated she had let the director of residential services (DRS) know about the allegation and had also notified human resources. The CEO stated she had not reported the allegation to the SA because she thought that was why the surveyor was at the agency. The CEO stated typically when an allegation of abuse was received she would report it to the SA. The agency's abuse policy was requested but not received. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 815		