DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed May 14, 2020

Administrator
Laura Baker Services Association
211 Oak Street
Northfield, MN 55057

Re: Project Number HG500051C, HG500052C
Event ID: QF1811

Dear Administrator:

On 4/23/20, 4/24/20, and 4/28/20, an abbreviated survey was completed to investigate complaint HG500051C and HG500052C. The complaint was found to be substantiated, with no licensing orders issued. Your facility is in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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,

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed May 14, 2020

Administrator
Laura Baker Services Association
211 Oak Street
Northfield, MN 55057

RE: Project Number HG500051C, HG500052C
Event ID: QF1811

Dear Administrator:

During this period of pandemic COVID-19 outbreak, State Agencies (MDH) are changing the process for survey prioritization and enforcement remedies. MDH is delaying revisit surveys and are exercising enforcement discretion during this prioritization period, beginning March 23, 2020. As a result, the below enforcement actions resulting from this survey cycle will be suspended until revisits are again authorized.

This letter also requests that your facility submit a plan of correction. Although revisit surveys will not be conducted during the prioritization period, you may still submit your facility's POC during this time and the case will be held. Your facility may delay submission of a POC until the prioritization period is over.

On 4/23/20, 4/24/20 and 4/28/20, an abbreviated survey was conducted to investigate HG500051C and HG500052C. The facility was found NOT to be in compliance with the requirements of 42CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

HG500051C and HG500052C were substantiated with deficiencies.

At the time of the complaint investigation the survey team noted one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the complaint invesitgation we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy on April 28, 2020.

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

W122 42 CFR § 483.420 Client Protections

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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:

Karen Aldinger, RN
HFE-Unit Supervisor, Metro Team A
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Office: 651-201-3794 | Mobile: 320-249-2805

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

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by **June 12, 2020**, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

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

Sincerely,

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01163	A. BUILDING: _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	**211 OAK STREET NORTHFIELD, MN 55057**

(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) COMPLETE DATE
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 4/23/20, 4/24/20, and 4/28/20, an abbreviated survey was completed to investigate complaint HG500051C and HG500052C. The complaint was found to be substantiated. No licensing orders were issued. Your facility is in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).	5 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	**211 OAK STREET NORTHFIELD, MN 55057**

(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 4/23/20, 4/24/20 and 4/28/20, an abbreviated survey was conducted to investigate HG500051C and HG500052C. The facility was found NOT to be in compliance with the requirements of 42CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). In addition, the Condition of Participation: Client Protection 42 CFR 483.420 was found not met. An extended survey in the the area of client protection was conducted. HG500051C and HG500052C were substantiated with deficiencies issued at W122 and W127. An Immediate Jeopardy was identified at W122 and W127 on 4/24/20 at 2:19 p.m. The Immediate Jeopardy began on 4/22/20, when C1 displayed eight aggressive behavioral incidents towards two vulnerable clients (C2, C3) in the home beginning 1/24/20, and no new interventions were identified by the facility to reduce the likelihood of future behavioral incidents/abuse to maintain the health and safety of the vulnerable clients in the home and reduce manic/behavioral symptom for C1. The immediate jeopardy was removed on 4/28/20, at 1:43 p.m when the facility implemented measures to protect residents and implement positive behavioral supports for C1.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client	W 122		

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
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 122	Continued From page 1 protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed to identify interventions to reduce the likelihood of behavioral incidents to maintain health and safety for the vulnerable clients in the home and reduce manic/behavioral symptoms when C1 had eight aggressive behavioral incidents, five of the incidents occurred between C1 and C2 (3/22/20, 3/24/20, 4/18/20 twice, and 4/22/20) and three incidents occurred between C1 and C3 (1/4/20, 3/24/20 and 4/7/20). This resulted in an immediate jeopardy for C2 and C3 due to the repeated physical abuse and risk for client health and safety. The Immediate Jeopardy began on 4/22/20, when C1 displayed eight aggressive behavioral incidents towards two vulnerable clients (C2, C3) in the home beginning 1/24/20, and no new interventions were identified by the facility to reduce the likelihood of future behavioral incidents to maintain the health and safety of the vulnerable clients in the home and reduce manic/behavioral symptom for C1. The immediate jeopardy was removed on 4/28/20, at 1:43 p.m when the facility implemented measures to protect residents and implement positive behavioral supports for C1. Findings include: See W127: The facility failed to identify interventions likely to reduce behavioral incidents	W 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	**211 OAK STREET NORTHFIELD, MN 55057**

(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 122	Continued From page 2 in an attempt to keep vulnerable clients in the home safe and reduce manic/behavioral symptoms for 2 of 5 clients (C2, C3) reviewed for abuse.	W 122		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify interventions likely to reduce behavioral incidents in an attempt to keep vulnerable clients in the home safe and reduce manic/behavioral symptoms for 2 of 5 clients (C2, C3) reviewed for abuse. This protection failure resulted in an immediate jeopardy (IJ) situation due to the physical abuse of C2 and C3. Facility staff had knowledge of continued aggressive behavioral incidents, five of which occurred between C1 and C2 (3/22/20, 3/24/20, 4/18/20 x 2, 4/22/20) and three which occurred between C1 and C3 (1/4/20, 3/24/20, 4/7/20). C1 had targeted C2 and C3 with hitting,slapping, including tipping over C2's wheelchair. No new programmatic or non pharmalogical interventions had been identified or implemented to reduce the likelihood of continued abuse. Findings include: C1's Individual Data (ID) face sheet dated 8/21/19, indicated she had moderate intellectual	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 3	W 127		

disabilities, bipolar disorder and Prader-Willi Syndrome (PWS) which is a genetic disorder with symptoms of behavior problems, intellectual disability, and short stature.

C1's Intensive Support Services Assessment (ISSA) dated 6/4/19, indicated she is ambulatory and able to access all common areas of her home. Staff conduct 30 minute visual checks when she is awake and 60 minute visual checks when she is sleeping. In addition, the assessment indicated she has a door alarm that is only armed when she is in a state of mania. The assessment indicated her signs of mania are rapid eye movement, involuntary movements of her limbs, vulgar language, repetitive speech/statements, disrobing, refusing to go to work, physical aggression and self-injurious behaviors (generally pinching her arms and thighs), if she has four or more of these staff are to turn on her door alarm.

C1's Individual Abuse Prevention Plan (IAPP) dated 6/4/19, indicated she has 24 hour supervision and staff provide visual or auditory supervision when she is around peers to ensure that interaction remain appropriate and staff will verbally or physically intervene if needed. Further the plan indicated staff follow her Behavior Support Plan (BSP) when she becomes physically aggressive. Staff will attempt to position themselves between C1 and others when she is aggressive or showing signs of possible aggression.

C1's Positive Behavioral Support Plan (BSP) dated 4/9/20, indicated C1 was able to communicate her wants and needs verbally but had difficulty accurately describing her emotions,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 4	W 127		

mood, or physical discomfort, her target behaviors were likely to increase in frequency and intensity. The plan further indicated in order to help minimize target behaviors, it was important for staff to encourage regular verbal self-expression. The plan listed the following target behaviors and interventions for staff to follow for physical aggression. Staff were to provide verbal redirection to another task, activity or opportunity to go to her room and relax. If she was physically aggressive towards her peers, staff were to immediately intervene by placing themselves between C1 and her peer and staff would relocate peer. In addition, the plan listed recommendations to help avoid target behaviors which included allowing her to make choices, structured schedule and magazine bin that assisted her in having certain magazines that she can access to allow her to pair visual activities to do throughout the day. The BSP further indicated she was seen by a psychiatrist and was prescribed Seroquel 25 milligrams (mg) daily. The plan indicated the qualified developmental disability professional (QDDP)-A was responsible for writing the plan, reviewing behavior data a minimum of quarterly, training of direct care staff during initial orientation, when changes are made to the plan and after the annual meeting.

C1's Functional Assessment Recommendations (FAR), dated 10/16/13, completed by department of human services (DHS) was given to the facility on 3/31/20, by C1's parents (FM-B, FM-C) according to a email sent by FM-B. The FAR, indicated the recommendations were to be used for the home and work supports. Staff were to allow her adult choices and reinforce her for making good choices, structured schedules, rehearsals of a set of phases that are made up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	**211 OAK STREET NORTHFIELD, MN 55057**

(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 127	Continued From page 5	W 127		

expectations, guidelines and or routine, using a timer to allow C1 a visual flow of how much time she has until she can do an activity, setting limits for her wanting to find pictures on the internet to know that things are predictable and all staff are on the same page, picture schedule routine, magazine/picture book. C1's records lacked evidence these recommendations were ever implemented.

C2's ID dated 4/15/20, indicated he had anxiety, dementia and profound intellectual disabilities and used a wheelchair for mobility. C2's IAPP updated 9/23/19, indicated he is non-verbal and would not assert himself in an abusive situations. Staff are to visually monitor him for any signs of abuse.

C3's ID dated 4/15/20, indicated she had profound intellectual disability, spasticity and delayed development. The ID further indicated she is in a wheelchair at all times and a hoyer for transfers. C3's IAPP dated 6/1/19, indicated she has limited cognitive and verbal abilities and would be unable to avoid or escape abuse. In addition, the IAPP indicated she has 24 hour awake staff and staff maintains constant auditory supervision and conduct 15 minute checks while awake and hourly while asleep. Staff will report any signs of maltreatment according to facility policy.

Review of General Events Reports (GERs) with C1 and C3, indicated three incidents of abuse from 1/4/20 to 4/7/20.

-1/04/20, C1 was heading to her room to calm down, entered her room and made a "meow" sound, resident counselor (RC)-E heard a slap

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 6	W 127		

sound and went to the hall to C1's room. C3 was in the door way, leaving her room. C3 had a left red cheek. C3 took a few minutes of singing and snacks to calm down and no longer visibly upset. Corrective action listed were for staff to stay near C3 when she was out of her room, set alarm on C1's door so staff would know when C1 was out of her room, and lock the doors to all bedrooms after clients went to bed so a key is needed to enter their rooms. The doors lock from the outside only, clients are not prevented from leaving their rooms.

- 3/24/20, C3 was in her room with her door shut with music on and decided to go into the hallway. Direct support staff (DSS)-B was in peers room and RC-B was getting keys from DSS-B when C1 went up to C3 and slapped her three times in the face. C1 then ran to her room and RC-B stood between C1 and C2 and placed C3 in her bedroom. C3 spent the rest of the evening in her bedroom with music on, her right cheek was red, and the redness was going away. The intervention listed was the QDDP-A would develop and train staff on how to better position themselves and/or other clients to limit the peer/s contact with other clients.

-4/07/20, DSS-A went to get a key to C1's door alarm, and during that short time, C1 came out of her room and began slapping C3. DSS-A immediately saw it and ran to get in between them and redirected C1 away from C3 and RC-C and brought C2 to her room and turned on her music. Plan of future action indicated household director will provide a second alarm key so at least two staff on the house have a key to her alarm at all times and to continue to have alarm on when she is in a manic state, and having a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 7	W 127		

staff stay between her and her peers when she is manic.

Although C1 had slapped C3 on three different occasions no new interventions were added except staff re-trained on better positioning and a second key was given to staff for C1's alarm. These same interventions failed to prevent C1 from abusing C3 and neither addressed possible interventions to change the aggressive behavior or symptoms of mania.

Review of the facility's GERs from 3/22/20 to 4/22/20 indicated C1 had 5 reports of abuse involving C2. The following GERs indicated:

-3/22/20, at 2:50 p.m. C1 ran out of the Elwell house with staff and ran back in the house and ran up to C2 with an open hand and slapped him across the left side of his face. C1 then stepped back and yelled at C2. The staff response to the incident indicated she placed herself between C1 and C2. C2 was then checked for injury and was unharmed. Staff moved other clients to their rooms for safety.

-3/24/20,at 9:15 a..m. C2 was wheeling himself around in the hallway while C1 was walking by him with staff and C1 reached over and slapped C1 on the left side of his face. The staff moved C2 in the living room away from C1 and checked C2 who appeared to be unharmed from being slapped. QDDP-A developed an in-service to remind staff of ways to position themselves for the protection of clients.

-4/18/20, at 8:15 a.m. C2 was sitting in the living room in his wheelchair while RC-A was assisting another client in her bedroom, RC-B went to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 8	W 127		

bathroom. When RC-B came out of the bathroom he saw C1 slap C2. RC-B turned C1 away from C2 and C1 went to her room while RC-B turned her door alarm on. C2 and other clients were put into there rooms. C2 had a red mark on his cheek from being slapped.

-4/18/20, at 3:00 pm C2 was sitting in his wheelchair hanging out by staff office and C1 became very obsessive about her personal belongings in the staff office. When C1 left the office, DSS-A was behind C1 and started to go in between C1 and C2 by putting her arm between them but C1's hand still managed to touch the right side of C2's face. No injury was noted. Then C1 left to go to her room and staff turned on the alarm to C1's room due to exhibiting signs of mania and the alarm alerts staff when C1 leaves her room so staff are aware of her presence. Corrective action was for staff to continue to follow her program for her door alarm when staff believe C1 is exhibiting signs of mania. Staff also were to redirect C1 as much as possible when she appears too manic and be aware of which clients are around her during this time. She tends to target some clients much more than others.

-4/22/20, at 5:00 p.m. RC-C was in the bathroom washing hands, RC-D was getting pizza out of the office for a birthday party while RC-B was with C1 the majority of the day due to mania. RC-B turned around to grab a bag of pop that was inside of the office. In a matter of seconds C2's chair was on its side. After the incident C1 stepped away giggling and stated he deserved to be hit. The report further indicated they did not actually see C1 do this but she was the only one standing there who could have done it. Two staff went in aid of C2. C1 agreed to go to her room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 9	W 127		

and calm down, alarm is always on, staff sat at her door the entire duration of the dinner party, afterwards she had her dinner.

Although there were five incidents where C1 targeted C2, there were no new interventions. There was only retraining of staff on positioning themselves between C1 and C2, redirecting and having C1's alarm on in her room. These same interventions failed to prevent C1 from abusing C2 and neither addressed possible interventions to change the aggressive behavior or symptoms of mania.

A prescription for C1 signed by certified nurse practioner (CNP) dated 3/26/20, indicated C1 was receiving Seroquel (antipsychotic) 25 milligrams (mg) daily and now was to receive it twice a day due to increased behaviors.

-4/11/20, Seroquel (antipsychotic) 25 milligrams (mg) at 7:00 p.m. was missed on 4/9/20.
-4/17/20, Seroquel 25 mg at 7:00 p.m. was missed on 4/16/20.
-4/20/20, Seroquel 25 mg at 7:00 p.m. was missed on 4/19/20.

A facility provided e-mail dated 4/20/20, from the facility registered nurse (RN)-A informing C1's family of the medication errors, indicated staff follow up was provided and education. RN-A sated the errors occurred from staff who normally do not work in the Elwell house. In addition, she indicated it is critical for C1 to receive her medications.

Although C1's Seroquel was increased to 25 mg twice daily she missed three doses which may have prevented her from receiving the maximum

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	**211 OAK STREET NORTHFIELD, MN 55057**

(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 127	Continued From page 10	W 127		

benefit of that dosage increase.

During observation 4/23/20, at 12:30 p.m. C2 was eating at the kitchen table in the dining room. C2 was in a wheelchair and was smiling. C2 did not respond when asked questions.

During observation 4/23/20, at 12:35 p.m. an alarm was observed to be outside of C1's room at the top right side of the door. C1 was lying in her bed with no clothes on, under her comforter. C1 then stood up and asked surveyor to leave her room.

During observation 4/23/20, at 12:38 p.m. C1 was observed to be dressed and ambulated independently to the dining room. C1 began eating black berries. C1 appeared content while eating and talking with staff.

During observation 4/23/20, at 3:09 p.m. C1 walked into the kitchen carrying a doll with no clothes on. C2 was observed sitting in his wheelchair in the hall infront of the staff office. RC-B was with C1 while she was walking around.

During interview 4/23/20, at 11:00 a.m. QDDP-B who stated he is responsible for reviewing GERs indicated C1 has had 8 incidents involving C1 with C2 and C3. The incident that had occurred on 4/22/20, involving C1 and C2, occurred in the evening when the staff were getting ready for a party, C1 was manic and tipped C2 and wheelchair to the ground. QDDP-B further stated she has been manic and this was the most aggressive she had been and the more manic she is the more aggressive. He further indicated she has an alarm on her door that lets staff know if she leaves her room. He stated staff used to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 11	W 127		

use a key to turn it on and on 4/20/20, they changed it to a alarm with a keypad so staff no longer need to use keys. QDDP-B further indicated when she is manic and near other clients staff position themselves in between them to prevent C1 from hitting them, but she is very quick and more mobile than half of the staff. The QDDP-B stated he felt the interventions were working. He stated C1 receives services from Southern Cities psychiatry and her Seroquel was recently increased due to behaviors. QDDP-B stated C2 seems to be a target for C1 and thinks it is because he seems to be closest to her when she is manic. He stated she is not on a 1:1 and typically they schedule two staff in the morning and three in the evening.

During interview 4/23/20, at 12:00 p.m. interview with the house hold director (HHD)-A stated she has been instructed when C1 is manic staff stay between C1 and peers until she is not manic. She indicated they also attempt to deescalate the situation by getting her involved in something. She also indicated when she is maniac they place the other clients in their rooms and lock the doors so she cannot enter their rooms. HHD-A stated the clients are able to unlock the doors from the inside of there rooms. In addition, HHD-A stated C1 has been at Elwell house for 14 years and they have not considered relocation of any of the clients to provide safety for them. She also indicated C1's behaviors have really increased since January and also increased due to COVID restrictions. She further indicated she was not aware of any picture program for her just that she likes to cut out pictures and tape them up.

During interview 4/23/20, at 12:10 p. m. HHD-A stated C1's Seroquel was increased on 3/26/20,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 12	W 127		

due to increased behaviors and it has not helped because she is till having incidents and she had missed 3 doses. HHD-A further stated it would be ideal if they always had three staff on but it does not happen due to staffing issues. She then stated C2 does nothing wrong to be hit by C1 and happens to just be the closest to her.

During interview 4/23/20, at 12:25 p.m. with resident counselor RC-C stated she was working on the evening of 4/22/20, when C1 tipped C2 and his wheelchair onto the floor. RC-C stated her behaviors increase during parities and they were having a client's birthday party that night. She stated they had three staff on but she is so quick it is difficult to prevent the incidents. Furthermore, she stated they just do not know when she is going to strike out and three of the five clients are dependent and vulnerable in the Elwell house.

During interview 4/24/20, at 2:43 p.m. DSS-A stated C1 goes after C2 and C3 because they are the most vulnerable. She indicated the interventions she has been instructed to use was to position herself between them and make sure C1's door alarm is on when she is manic. DSS-A stated the interventions help somewhat but the incidents continue to happen and this is the most manic she has seen her. She further stated she was not aware of any other interventions they have for C1.

During interview with QDDP-B 4/23/20, at 3:30 p.m. he stated the campus director and the QDDP for Elwell house are both behavioral analysts and the assessments are completed by her and he makes the initial interventions when he reviews the GER. He further went on to say

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 13	W 127		

prior to the most recent incidents she has not had any since November 2019 and since the lockdown everything has changed since she is no longer able to go to day program or have visits from her parents. Although he did state prior to the lock down C1 was refusing to go to work for about 2 1/2 weeks.

An additional interview 4/23/20, at 5:12 p.m. QDDP-B stated staff call him right away when an incident occurs and they talk about the incident and he directs the staff on what to do. He stated he makes the decisions, and can suspend staff if needed pending investigation. He stated he talks with the QDDP involved in the house where the incident occurs. The QDDP who works at the Elwell house currently is working from home 90% of the time due to COVID and she is already working on a picture and a reward program for C1 to decrease her behaviors. In addition, he stated QDDP for Elwell updated C1's careplan and the behavioral support plan on 4/9/20, following recommendations from the county on 10/16/13. QDDP-B stated they had recently just received the FAR from C1's parents and they had not been implemented the recommendations yet. In addition, he stated they have gone through several QDDP's for the Elwell house and things had slipped through the cracks.

During interview 4/24/20, at 8:14 p.m. with C2's family member (FM)-A who stated she is at the Elwell house many times prior to COVID and the house is very hectic and seems short staffed. FM-A then stated the staff call her when a client hits him. She then stated he is on hospice in a wheelchair and cannot defend himself and all they want for him is to be, "comfortable, happy and safe." In addition, she stated she does not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 14	W 127		

know his life expectancy but wants him to be content with, "no conflict."

During interview 4/24/20, at 9:20 p.m. via phone, FM-B and FM-C stated they used to visit C1 at the home until the COVID restrictions. They indicated on 2/20/20, there was a incident where they felt staff had abused C1 and dragged her on the floor and caused severe abrasions to her skin and they feel C1's mania has increased since that incident. They continued to state she is not sleeping either and feel it is due to her fear. They also stated on 3/26/20, her Seroquel was increased but there was three medication errors of missed evening doses and that has not helped her situation. Further, they stated C1 was seen by DHS 10/13/16, and recommendations were made to help deal with her behaviors and the facility had never implemented any of these interventions to help her. They stated they feel she needs emotional support and a counselor which has been difficult due to the COVID which prevents her to have a face to face visit.

During interview 4/24/20, at 9:01 a.m. with QDDP-C who stated she started about two months ago and works in the Elwell house and another house and oversees 10 clients. QDDP-C stated C1 has been very manic and all of the clients' schedules have changed due to COVID and it is very difficult. She indicated she has been working from home and has done some training with the staff on proper positioning but has not implemented any of the recommendations from the FAR. She further stated she had not completed a current assessment on C1 but used the recommendations from 2016 because C1's family said they were still current. In addition, she stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 15	W 127		

C1 had an alarm to alert staff if she leaves her room and staff try to position themselves between her to prevent incidents with C1 and other clients. She did state it is difficult to prevent the incidence because C1 is so manic and quick. She did state it would not hurt to try more interventions for C1.

Review of email from the director of Oak Street Services dated 4/23/20, at 9:28 a.m. sent to QDDP-B, QDDP-C, and HHD-A was reviewed. The email indicated she had remembered reading about a picture schedule and questioned if it had been implemented and if not needed to be done ASAP. In addition, the email indicated to set up attention time free and clear and recognizing when she is good. The email further indicated she was wondering what training has been done for the BSP and acknowledged they had staff read it, however, she felt is was essentially just a check off box for them and was not necessarily good training. Futher she indicated they need to make sure each staff understand how to implement the BSP and demonstrate competency. Following the email QDDP- C responded, "I think it might be necessary, from now on, to have three staff on at all times and one staff specifically assigned to C1."

The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 3/5/19, indicated any employee or volunteer who has reason to believe a vulnerable adult or minor is being or has been maltreated must report it immediately. When the mandated reporter has reason to believe a report needs to be made, he/she must ensure clients are safe and have appropriate supervision. In addition, the report indicated the program's mandated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 127	Continued From page 16 reporter or designee shall be responsible for reviewing and investigating the report, and directing or taking any and all actions to insure the safety of the vulnerable person, including, as appropriate, removing the alleged perpetrator from direct contact with the alleged victim. The immediate jeopardy was removed on 4/28/20, at 1:43 p.m. when the facility implemented measures to protect residents by re-educating staff, updating C1's BSP, placing a reward system and reinforcement program for C1 and the QDDP-C will now be working onsite fulltime.	W 127		