

Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed August 13, 2020

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

RE: Event ID: X1CR11

Project numbers: HG500056C, HG500059C

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 July 21, 2020 through July 23, 2020, an abbreviated survey was conducted to investigate HG500056C and HG500059C. The facility was found not to be in compliance with the requirements of 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID).

HG500056C was substantiated with deficiencies issued. HG500059C was substantiated with no deficiencies issued.

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.

W-0122 Client Protection 42 CFR 483.420

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.

Laura Baker Services Association

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:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301

Email: susie.haben@state.mn.us

Phone: 320-223-7356 Fax: 320-223-7348

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 **September 6, 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,

Any Johour

Amy Johnson, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Telephone: 651-201-4121 Fax: 651-215-9697



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

Re: Project Number: HG500056C, HG500059C

Evenit ID: XICR11

Dear Administrator:

The above facility survey was completed on July 23, 2020 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56.

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,

Any Johour

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

PRINTED: 08/13/2020 FORM APPROVED

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | | (X3) DATE SURVEY COMPLETED | | |
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| /IDER OR SUPPLIER | | | , , | STATE, ZIP CODE | | |
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| at may result from ders provided that the Department with tice of assessment 7/21/20 through rvey was comple 6500056C and Here found to be suders were issued th requirements of | n non-compliand t a written reque hin 15 days of re ent for non-comp 7/23/20, an abb ted to investigat G500059C. The ubstantiated. No your facility is i of Minnesota Ru | ee with these est is made to eccipt of a diance. ereviated e complaint e complaints o licensing n compliance les, Chapter | | | | |
| | CORRECTION VIDER OR SUPPLIER ER SERVICES AS SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE tial Comments accordance with 4.56 and/or Minn 4.653, this correct result to a surve and that the defice rein are not correct to corrected shall the a schedule of five the modern and MN Ru licated below. We were items, failure ments of the modern and MN Ru licated below. We were items, failure ms will be conside to compliance m of multi-part ru sessment of a fin alted during the items of modern and the items at may request a at may request a at may request a at may request a at may result from the popuration of the popuration of the tice of assessment at may request a at may request a at may request a at may result from the popuration of the popuration of the tice of assessment at may request a at may request a at may result from the popuration of the tice of assessment at may request a at may request a at may result from the popuration of the tice of assessment at may request a at may result from the popuration of the tice of assessment at may request a at may result from the popuration of the tice of assessment at may request a at may result from the popuration of the tice of assessment at may request a at may requ | DIDENTIFICATION O1163 WIDER OR SUPPLIER ER SERVICES ASSOCIATION SUMMARY STATEMENT OF DEFICIE (EACH DEFICIENCY MUST BE PRECEDE REGULATORY OR LSC IDENTIFYING INFINITION OF LSC IDENTIFY | ### TOTAL PROPERS OF THE PROPERS OF | DIDENTIFICATION NUMBER: 01163 B. WING | ### DOTAINS CONTRICTION NUMBER: 01163 B. WING | DIDENTIFICATION NUMBER: 01163 DIDENTIFICATION NUMBER: 211 OAK STREET NORTHFIELD, MN 55057 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFING INFORMATION) DIDENTIFICATION OR LSC IDENTIFING INFORMATION) DIDENTIFICATION OR LSC IDENTIFING INFORMATION) DISTRICT TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DIDENTIFICATION OR CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 5 000 DISTRICT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DID PROVI |

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

TITLE (X6) DATE

PRINTED: 08/13/2020 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | LE CONSTRUCTION G | | TE SURVEY MPLETED |
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| W 000 | survey was conduct and HG500059C. The facility must er protection seed on interview Condition of Particic Client Protection, we to protect a client work of the condition of Particic Client Protection, we to protect a client with Part 483, subpart I. Care Facilities for I Disabilities (ICF/ID In addition, the Corprotection 42 CFR HG500056C was sissued at W122, WHG500059C was sissu | th 7/23/20, an abbreviated sted to investigate HG500056C The facility was found not to be the requirements of 42 CFR, requirements for Intermediate ndividuals with Intellectual). Indition of Participation: Client 483.420 found not met. Substantiated with deficiencies 127, Substantiated with no 1. Complaint investigations also identified at W153 and TIONS | W | | | | |
| ADODATOD | reviewed for abuse | ed for 1 of 1 clients (C20) : DER/SUPPLIER REPRESENTATIVE'S SIG | NATURE. | | TITLE | | (X6) DATE |

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

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| W 122 | Findings include: See W127: The fa from verbal abuse | cility failed to protect a client from staff for 1 of 1 clients | W | 22 | | | |
| W 127 | (C20) reviewed for PROTECTION OF CFR(s): 483.420(a) | CLIENTS RIGHTS ((5) | W | 27 | | | |
| | Therefore, the facil | sure the rights of all clients. ity must ensure that clients are ysical, verbal, sexual or e or punishment. | | | | | |
| | Based on observative review, the facility fabuse when a staff | s not met as evidenced by: tion, interview and document ailed to protect a client from member was alleged to make rt a client for 1 of 1 clients abuse. | | | | | |
| | Findings include: | | | | | | |
| | 7/21/20, indicated h EDF further indicated | Data Form (EDF) dated ne admitted on 7/11/1980. The ed he had profound intellectual nd panic attacks. In addition ne was non-verbal. | | | | | |
| | dated 2/26/20, indic himself from a abus during all waking he p.m. to 6:30 a.m. as situations. All staff abuse and will follo procedure. Further | use Prevention Plan (IAPP) cated he would not remove sive situation, and has 1:1 staff ours with the exception of 10 and redirect from abusive are trained to monitor for w the internal reporting the IAPP indicated his 1:1 per shift. Lastly the IAPP | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION ING | | TE SURVEY MPLETED |
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| W 127 | indicated he does remove himself from verbally aggressive staff. A Common Entry Reported by qualified professional (QDDF) July 13th, the house lives notified QDDF had reported some towards [C20] from person reporting satisfied professional (QDDF) had reported some towards [C20] from person reporting said that of [DSS-X] and [DSS-X] and [DSS-X] and [DSS-X] and poking kept doing that she would "breefurther went on to in DSS-X and poking kept doing that she A General Events F7/17/20, indicated Cprevious staff) and C20 and she did not feel DSS-X wou QDDP-B (facility prattempted to contact all in the last 30 days a could not confirm a did not indicate what in the last 30 days a could not confirm a did not indicate what in the last 30 days a could not confirm a did not indicate what in the last 30 days a could not confirm a did not indicate what is the last 30 days a could not confirm a did not indicate what is the last 30 days a could not confirm a did not indicate what is the last 30 days a could not confirm a did not indicate what is the last 30 days a could not confirm a did not indicate what is the last 30 days a could not confirm a did not indicate what is the last 30 days a could not indicate what is the last 30 days a could not indicate what is the last 30 days a could not indicate what is the last 30 days a could not indicate what is the last 30 days a could not indicate what is the last 30 days a could not indicate what is the last 30 days and 100 days and 1 | cot acknowledge needing to m a area of physically or person thus needs 1:1 with seport (CEP) dated 7/13/20, d developmental disability P)-R indicated, "On Monday, ehold director where [C20] P, that a previous staff [DSS-J] verbal threats directed another staff person. The hid that she heard direct X] threaten to "break [C20]'s 20]'s fingers." The person during the incident, [C20] bit X] told [C20] if he kept doing ak his teeth." The report andicate C20 kept pointing at at her and she told him if he would break his fingers. Resolution (GER) dated QDDP-R contacted DSS-J (the she stated DSS-X threatened at report this because she did all follow through with it. Or or and she did not answer to voice mails. Furthermore, by QDDP-B an attempt was staff who worked with DSS-X and staff who are employees my threats to C20. The report at QDDP-B's conclusion was closed and signed by the | W 1 | 27 | | |

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| W 127 | During interview or QDDP-R who state allegation and calle allegation was true had witnessed the had not reported the because she did not hurt C20. C20 was date. QDDP-R state of the incident who During interview or QDDP-B stated foll the report was inco have any problems disciplinary actions he looked today. In multiple attempts to return his calls, ever would be calling. It allegations. He suit did hear back from he felt the investigation of the incident who would be calling. It allegations allegations and the felt the investigation of the felt the investigation of the following: Interview with DSS threatened or told of the collowing with DSS threatened or told of the collowing with DSS DSS-X use some results. | in 7/21/20, at 9:30 a.m. with and she was informed of the ad DSS-J to confirm if the adding DSS-J confirmed she werbal abuse and that DSS-J e allegation as required but think DSS-X would actually unable to provide a specific ed she then notified QDDP-B notified the administrator. In 7/21/20, at 1:00 p.m. lowing his investigation, he felt inclusive because he did not with DSS-X and she had no in her employment file when the further stated he made or reach DSS-J and she did not en though QDDP-R told her IDSS-X also denied the marized by stating, since he DSS-J and had no concerns, ation was inconclusive. ER Resolution dated 7/16/20, adated by the director of oak DCS), indicated QDDP-B had dated 7/14/20 to 7/15/20 (no with staff, which concluded S-X stated she has never C20 she would harm him. | W 12 | 2.7 | | |

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| W 127 | from door. But did but could be gentled -Interview with HHI Oak who stated with C20 break, she had counced in the past. So not schedule DSS-prevent burn-out be challenging/exhaus. A facility e-mail ser QDDP-R and direct indicated, "An alleg verbally threatened of this allegation is was not sustain/prowork as scheduled meet with you Mon recommendations internal review." During observation was walking around was walking around was following him aroom with him. During interview 7/ administrator state in reporting and shreported this incided worked at the facili internal investigation interviewing, QDDF more questions whyelled, named called out more informatic QDDP-B had received. | not think DSS-X was abusive or when turning him. D-Q (former HHD) at North nen DSS-X was impatient or a she would offer to give her a unseled DSS-X about yelling at he further indicated she would X for multiple days in a row to ecause C20 can be | W 12 | 7 | | |

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| W 127 | the only one who DSS-J about the enough. The adrifollowing up with the enough. The adrifollowing up with the enough. The adrifollowing: - Employee Discip 5/17/12, indicated and violation of preport indicated it report further indicated it report further indicated; hostile of staff and students clients that attend the end of indicated [DSS-X] frustrated with clients with the end of indicated internal review of indicated interview of indicated interviews a written with the end of the signed by QDDP-QDDP-B's intervation be inconclusive several interviews could be rough and Furthermore, QD questions of the sprovided regardin verbal abuse of color addition, DSS-2 | and even though QDDP-R was received the interview from allegation that should be ninistrator stated she will be QDDP-B. employee file indicated the olinary Report (EDR) dated I DSS-X had improper conduct olicy and procedures. The was written warning. The cated DSS-X was making omments and directives to other (Laura Baker school with led). 20, indicated incident 7/13/20, ractions with clients. "During an an allegation, several persons may be exhausted and/or ent behavior and responded by inguage that is contrary to the respect." The EDR indicated arning and consequence would be and including termination in B and DSS-X on 7/21/20. all investigation was determined a despite having interviews from the from staff stating she was loud, and was name calling, DP-B failed to asked additional staff when information was ag potential rough handling and | W | 127 | | |

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| W 127 | procedure, without her performance ar without adequate mare commendation to allowed to work exceptions allowed to work exceptions interview 7/2 director of oak servaceiving training on neglect policies tod was developed by madequate oversight interacations with Commendation of the facility Policy & Prevention & Reportevised 5/7/2020, in volunteer who has adult or minor is be must report it immereporter has reason be made, he/she mad have appropriate report indicated the or designee shall be and investigating that taking any and all at the vulnerable personner removing the allege contact with the all | g of the abuse policy and supervision and monitoring of and interaction with clients and nonitoring or enforcement of the ensure DSS-X was not be dessive hours with C2. 22/20, at 10:30 a.m. the dices confirmed DSS-X was no vulnerable adult abuse and an ay and a monitoring system management to ensure the of her work hours and c20. A Procedures for the ring of Individual Maltreatment adicated any employee or reason to believe a vulnerable sing or has been maltreated the diately. When the mandated in the believe a report needs to fust ensure clients are safe at supervision. In addition the exprogram's mandated reporter the responsible for reviewing the report, and directing or actions to insure the safety of the control insure that all allegations of the control insure that all alleg | W 1 | | | |
| | The facility must en mistreatment, negle injuries of unknown | sure that all allegations of | | | | |

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| W 153 | officials in accordate established procedor. This STANDARD Based on interview facility failed to immadministrator and statements. | is not met as evidenced by: w and document review, the nediately contact the state agency for 1 of 1 clients | W 15 | 53 | | |
| | Findings include: C20's Emergency 7/21/20, indicated a diagnosis of prof | Data Form (EDF) dated he admitted on 7/11/1980 with ound intellectual disability, attacks. In addition the form on-verbal. | | | | |
| | dated 2/26/20, indi himself from a abu during all waking h p.m. to 6:30 a.m. a situations. All staf abuse and will follo procedure. Furthe staff will be rotated indicated he does remove himself from | ouse Prevention Plan (IAPP) cated he would not remove sive situation, and has 1:1 staff ours with the exception of 10 and redirect from abusive f are trained to monitor for ow the internal reporting r the IAPP indicated his 1:1 per shift. Lastly the IAPP not acknowledge needing to me a area of physically or experson thus needs 1:1 with | | | | |
| | reported by qualifice professional (QDD July 13th, the hous lives notified QDD had reported some | Report (CEP) dated 7/13/20, ed developmental disability P)-R, indicated "On Monday, sehold director where [C20] P, that a previous staff (DSS-J) e verbal threats directed a another staff person. The | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | TIPLE CONSTRUCTION | | TE SURVEY MPLETED | |
|--------------------------|--|--|-------------------|--|-----------------------------------|----------------------------|--|
| | | 24G500 | B. WING | | 07 | C / 23/2020 | |
| | PROVIDER OR SUPPLIE | | | STREET ADDRESS, CITY, STATE, 2 211 OAK STREET NORTHFIELD, MN 55057 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| W 153 | person reporting support staff [DS3 teeth" or "break [Greporting said that [DSS-X] and [DSS-X] and [DSS-X] and pokin kept doing that she would "brown further went on to DSS-X and pokin kept doing that she would "brown further went on to DSS-X and pokin kept doing that she would "brown further went on the staff" of the second staff" of the second further and the last 30 days threats to C20. Losed by the facing the report did not conclusion was brown further was sometime and the staff of the staf | page 8 said that she heard direct S-X] threaten to "break [C20]'s C20]'s fingers." The person it during the incident, [C20] bit S-X] told [C20] if he kept doing reak his teeth". The report indicate C20 kept pointing at g at her and she told him if he he would break his fingers. Resolution (GER) dated I QDDP-R contacted DSS-J (the d she stated DSS-X threatened not report this because she did bould follow through with it. Forogram mandated reporter) act DSS-J multiple times to actions and she did not answer by to voice mails. Furthermore and by QDDP-B an attempt was all staff who worked with DSS-X by and no staff could confirm any astly this report indicted it was allity administrator on 7/17/20. It indicate what QDDP-B's at was signed by the I/21/20 at 9:30 a.m. with ted she was informed of the all led DSS-J to see it was true and stated she did not report the te or the facility administrator. DSS-J was unsure the exact date w she started after COVID so it ter March 2020 and she only a few months. QDDP-R then of the incident who notified the | W | 153 | | | |

| | | | E SURVEY IPLETED | | | |
|--------------------------|--|--|---------------------|--|------|----------------------------|
| | | 24G500 | B. WING | | | C |
| NAME OF F | PROVIDER OR SUPPLIER | 24000 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 071 | 23/2020 |
| | BAKER SERVICES AS | SOCIATION | | 211 OAK STREET NORTHFIELD, MN 55057 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| W 153 | • | | W 1 | 53 | | |
| W 154 | revised 5/7/2020, in volunteer who has a adult or minor is be must report it immersafe and have appraddition the policy in must be notified. STAFF TREATMENTER CFR(s): 483.420(d) The facility must haviolations are thoroused for the facility failed to thoroused facility failed fai | ting of Individual Maltreatment idicated any employee or reason to believe a vulnerable ing or has been maltreated diately and ensure clients are opriate supervision. In indicated the administrator IT OF CLIENTS (3) ve evidence that all alleged ughly investigated. Is not met as evidenced by: and document review, the oughly investigate allegations client (C20) reviewed for staff Data Form (EDF) dated the admitted on 7/11/1980 with bound intellectual disability, ttacks. In addition the form | W 1 | 54 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED | |
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| | | 24G500 | B. WING_ | | 07 | /23/2020 | |
| | 24G500 ME OF PROVIDER OR SUPPLIER AURA BAKER SERVICES ASSOCIATION X4) ID REFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | STREET ADDRESS, CITY, STATE, ZIP CODE 211 OAK STREET NORTHFIELD, MN 55057 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| W 154 | procedure. Further staff will be rotated indicated he does remove himself frowerbally aggressive staff. A Common Entry reported by qualification professional (QDE) July 13th, the houlives notified QDD had reported some towards [C20] from person reporting support staff [DSS-teeth" or "break [Composed to the composed | er the IAPP indicated his 1:1 d per shift. Lastly the IAPP not acknowledge needing to om a area of physically or reperson thus needs 1:1 with Report (CEP) dated 7/13/20, ed developmental disability DP)-R, indicated "On Monday, sehold director where [C20] PP, that a previous staff (DSS-J) e verbal threats directed manother staff person. The said that she heard direct S-X] threaten to "break [C20]'s C20]'s fingers." The person that during the incident, [C20] bit S-X] told [C20] if he kept doing reak his teeth". The report indicate C20 kept pointing at g at her and she told him if he e would break his fingers. Resolution (GER) dated QDDP-R contacted DSS-J (the d she stated DSS-X threatened | W 15 | 54 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ' | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED | |
|--|--|--|---------------------|--|------------|----------------------------|--|
| | | 24G500 | B. WING | | 07/23/2020 | | |
| | PROVIDER OR SUPPLIER | SSOCIATION | | STREET ADDRESS, CITY, STATE, ZIP CODE 211 OAK STREET NORTHFIELD, MN 55057 | | | |
| (X4) ID PREFIX TAG | RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH APPROVIDED TO THE APPROVIDENCY) | OULD BE | (X5) COMPLETION DATE | |
| W 154 | indicate what QDD report was signed I During interview 7/s stated he felt the rebecause he did not DSS-X and had no employee file wher stated he made musured and she did not ret QDDP-R told her halso denied the allehe did hear back froncerns he felt the inconclusive. Furtidid not interview th had no explanation that as part of his part of h | P-B's conclusion was but the by the administrator. 21/20 at 1:00 p.m. QDDP-B eport was inconclusive thave any problems with disciplinary actions in her in he looked today. He further altiple attempts to reach DSS-Jurn his calls even though we would be calling. DSS-X egations. He then stated since for DSS-J and had no envestigation was thermore QDDP-B stated he envestigation was the other clients in the home and has to why he did not include process. ER Resolution dated 7/16/20, and dated DDP-B had several 14/20 to 7/15/20 with no times, included the following: | W 15 | 54 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 24G500 | B. WING | | 07 | C / 23/2020 |
| | PROVIDER OR SUPPLIER | SSOCIATION | | STREET ADDRESS, CITY, STATE, ZIP 211 OAK STREET NORTHFIELD, MN 55057 | | |
| (X4) ID PREFIX TAG | ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| W 154 | Despite having several stating DSS-X was clients, and was obsuch as "brat", as a previous concerns supervisor of her dQDDP-B's determinabuse due to being himself (even thou interviewed and reabuse and physical because there was recorded in DSS-X more QDDP-B failed investigation when regarding aggressing interviews gathered when QDDP-B failed for the internal investigation when reporting the incident the MAARC [Minner Center] the program begin the internal investigation included in this polimpartial investigation also include an evapolicies and proces whether or not the | EX for multiple days in a row to ecause C20 can be sting. Veral interviews from staff a loud, could be rough with eserved calling clients names well as gaining a history of from her previous house irect behavior towards C20, nation was inconclusive to gunable to contact DSS-J gh QDDP-R had already ceived her report of the verbal I threat made by DSS-X) and a not any history of concerns its employee file. Further ed to complete a thorough he did not inquire further ve behavior reported during did during the investigation and ed to interview clients as part estigation. Vised 5/7/20, indicated 5. After ent of alleged abuse/neglect to esota Adult Abuse Reporting ms mandated reporter will investigation. The program sible for using the checklists icy for conducting a fair and ion. The internal review will aluation of whether related dures were followed and y were adequate, if there is a | W 1: | 54 | | |
| need for additional staff training. Further the policy indicated "If the report alleges abuse or neglect by a care giver, determine if the caregiver is a threat to the alleged victim or others." | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | FIPLE CONSTRUCTION NG | (X | (X3) DATE SURVEY COMPLETED | | |
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| | | 24G500 | B. WING | | 07/23/2020 | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | ODE | 0112312020 | | |
| LAUDAD | AKER SERVICES AS | PROCIATION | | 211 OAK STREET | | | | |
| LAUKA D | AKER SERVICES AS | SOCIATION | | NORTHFIELD, MN 55057 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DA | TE SURVEY MPLETED |
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| • | | 24G500 | B. WING | | | 07 | C /23/2020 |
| | PROVIDER OR SUPPLIER BAKER SERVICES A | | | 211 | EET ADDRESS, CITY, STATE, ZIP CO OAK STREET RTHFIELD, MN 55057 | DE | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI TAG | | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (XS) COMPLETE DATE |
| W 000 | INITIAL COMMEN | ıts | wo | 000 | | | |
| W 122 | survey was condu- und HGS00059C. In compliance with Part 483, subpart I Care Facilities for Disabilities (ICF/IC In addition, the Co Protection 42 CFR HG500056C was Issued at W122, V HG500059C was deficiencles issued As a result of the deficiencles were W154. CLIENT PROTEC CFR(s): 483.420 | ndition of Participation: Client t 483.420 found not met. substantiated with deficiencies V127, substantiated with no d. complaint investigations also identified at W163 and TIONS | | 122 | John Andrew | a) lol | 0 |
| | This CONDITION Based on intervie Condition of Partic Client Protection, to protect a client by a staff member | Is not met as evidenced by: w and document review, the cloation at 42 CFR 483.420 was not met. The facility falled who was being verbally abused that was not immediately ted for 1 of 1 clients (C20) | | | | | |
| IORATOR | OF PROV | ODER/SUPPLIER REPRESENTATIVE'S SI | GNATURE | cili | HL Administrati | N 8/ | (X6) DATE 22/2 |
| / deficier er safegi | ký statement ending wit uards provide sufficient p | noen/Supplier Representative's Si h an asterisk (*) denotes a deficiency protection to the patients. (See instruct or not a plan of correction is provided, nents are made available to the facility | which the in | | n may be excused from correcting paurang homes, the findings stated at | | 22 termined sable 90 isolosab |

PRINTED: 08/13/2020 FORM APPROVED OMB NO. 0938-0391

| | | & MEDICAID SERVICES | | | CONOTRUCTION | (X3) DATE | SURVEY |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | COME | PLETED |
| AND PLAN O | F CORRECTION | DENTI IOMION ROMBER | A' RAILL | JING _ | | | |
| | | 24G500 | B. WING | _ | | 1 | 23/2020 |
| NAME OF F | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | SCOCIATION | | | 1 OAK STREET | | |
| LAURA B | BAKER SERVICES AS | BOUGHTION | | No | ORTHFIELD, MN 55057 | | 0/5 |
| (X4) ID PREFIX TAG | /EACH DEFICIENC! | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | DBE | (X5) COMPLETION DATE |
| W 000 | INITIAL COMMEN | TS | W | 000 | | | |
| W 122 | survey was conduct and HG500059C. In compliance with Part 483, subpart I Care Facilities for I Disabilities (ICF/ID In addition, the Corprotection 42 CFR HG500056C was a issued at W122, WHG500059C was a deficiencies issued at W124. CLIENT PROTEC CFR(s): 483.420 The facility must exprotections required This CONDITION Based on intervier Condition of Partic Client Protection, to protect a client by a staff member reported or protect reviewed for abuse 10 particular protect or protect a client protect or protect a client by a staff member reported or protect a client protect or protect a client by a staff member reviewed for abuse 10 particular protect or protect a client protect or protect or protect a client protect and protect a | ndition of Participation: Client 483.420 found not met. Substantiated with deficiencies /127, Substantiated with no d. Complaint investigations also identified at W153 and TIONS Insure that specific client ements are met. is not met as evidenced by: we and document review, the cipation at 42 CFR 483.420 was not met. The facility failed who was being verbally abused at that was not immediately sted for 1 of 1 clients (C20) te. | | 122 | 20 | 11cd2 | |
| 11000:000 | AN DIDECTORIS OF BROW | /IDER/SUPPLIER REPRESENTATIVE'S SIG | SNATURE | | TITLE | | (X6) DATE |
| LABORATOR | SA DIKECTOR 2 OK SKOT | ADEMOUT FIEW VELVEORIA WILLIAM ON | | | | | |

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.

Facility ID: 01163

| STATEMEN AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | LTIPLE CONSTRUCTION DING | (X3) DAT | E SURVEY MPLETED |
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| | | 24G500 | B. WING | S | I | C |
| LAURA | PROVIDER OR SUPPLIER BAKER SERVICES AS | | | STREET ADDRESS, CITY, STATE, ZIP CO 211 OAK STREET NORTHFIELD, MN 55057 | DDE | /23/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (| SHOULD BE | (X5) COMPLETION DATE |
| W 122 | Findings include: See W127: The factorism verbal abuse from verbal abuse from the factorism in the factoris | ility failed to protect a client | W 1 | 122 | | 9/23/20 |
| | (C20) reviewed for a PROTECTION OF CCFR(s): 483.420(a)() The facility must ensist therefore, the facility not subjected to phy psychological abuse This STANDARD is Based on observation review, the facility far abuse when a staff in verbal threats to hurt (C20) reviewed for a Findings include: C20's Emergency Da 7/21/20, indicated he EDF further indicated disability, anxiety and the form indicated he C20's Individual Abust dated 2/26/20, indicated he C20's Individual Abust dated 2/26/20, indicated himself from a abusin during all waking hou p.m. to 6:30 a.m. and situations. All staff ar abuse and will follow procedure. Further the | sure the rights of all clients. y must ensure that clients are sical, verbal, sexual or or punishment. not met as evidenced by: on, interview and document iled to protect a client from nember was alleged to make a client for 1 of 1 clients buse. ata Form (EDF) dated admitted on 7/11/1980. The I he had profound intellectual panic attacks. In addition was non-verbal. se Prevention Plan (IAPP) ted he would not remove re situation, and has 1:1 staff rs with the exception of 10 redirect from abusive te trained to monitor for | W 1. | All investigations will be reviewed for to assure all clients have been protect. All QDDP's will be trained by the facil on policy of suspending staff immedia maltreatment report has been made. All investigations are reviewed by the and facility administrator within 3 days. | ity administrator ately when a | |

| CENTERS FOR MEDICARE & MEDICARD SERVICES | | | | | (X3) DATE SURVEY | | |
|--|---|---|-------------------|-------|--|------|----------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | E CONSTRUCTION | | LETED |
| AND PLAN O | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | ING _ | | | ; |
| | | 24G500 | B. WING | i | | _ | 3/2020 |
| | OR OLUMBIA | 24G500 | STREET ADDRI | | | | |
| | PROVIDER OR SUPPLIER | | | ļ . | 11 OAK STREET | | |
| LAURA E | BAKER SERVICES AS | SSOCIATION | | N | ORTHFIELD, MN 55057 | | |
| (X4) ID PREFIX TAG | EIX (EACH DEFICIENCY MUST BE PRECEDED BY POLL | | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY), |) BE | (X5) COMPLETION DATE |
| W 127 | remove himself fro verbally aggressive staff. A Common Entry F | not acknowledge needing to m a area of physically or e person thus needs 1:1 with Report (CEP) dated 7/13/20, and developmental disability | W | 127 | | | |
| | reported by qualified developmental disability professional (QDDP)-R indicated, "On Monday, July 13th, the household director where [C20] lives notified QDDP, that a previous staff [DSS-J] had reported some verbal threats directed towards [C20] from another staff person. The person reporting said that she heard direct support staff [DSS-X] threaten to "break [C20]'s teeth" or "break [C20]'s fingers." The person reporting said that during the incident, [C20] bit [DSS-X] and [DSS-X] told [C20] if he kept doing that she would "break his teeth." The report further went on to indicate C20 kept pointing at DSS-X and poking at her and she told him if he kept doing that she would break his fingers. | | | N. | | | |
| | 7/17/20, indicated previous staff) and C20 and she did r not feel DSS-X wo QDDP-B (facility pattempted to contact confirm the allega her phone or reply the report indicate made to contact a in the last 30 days could not confirm did not indicate w | Resolution (GER) dated QDDP-R contacted DSS-J (the dishe stated DSS-X threatened not report this because she did ould follow through with it. program mandated reporter) act DSS-J multiple times to tions and she did not answer to voice mails. Furthermore, and by QDDP-B an attempt was all staff who worked with DSS-X and staff who are employees any threats to C20. The report that QDDP-B's conclusion was a closed and signed by the 7/17/20. | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|--------------------|----------------|---|---|---|
| 7 | | 24G500 | B. WING | | | | С |
| | PROVIDER OR SUPPLIER BAKER SERVICES AS | | B. WING | S7 21 | TREET ADDRESS, CITY, STATE, ZIP CODE | 07/ | /23/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | IX | ORTHFIELD, MN 55057 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | RE | (X5) COMPLETION DATE |
| | QDDP-R who stated allegation and called allegation was true, had witnessed the whad not reported the because she did not hurt C20. C20 was udate. QDDP-R stated of the incident who report was incompared to the report was incompared to the report was incompared to return his calls, even would be calling. Descriptions. He sum did hear back from Eat 1:29 p.m. last updated to the report was incompared to return his calls, even would be calling. Descriptions. He sum did hear back from Eat 1:29 p.m. last updated to the felt the investigations. The sum did hear back from Eat 1:29 p.m. last updated to the following: -Interview with DSS-2 threatened or told C2-Interview with DSS-2 interview with DSS-2 | 7/21/20, at 9:30 a.m. with dishe was informed of the did DSS-J to confirm if the adding DSS-J confirmed she rerbal abuse and that DSS-J allegation as required think DSS-X would actually unable to provide a specific dishe then notified QDDP-B notified the administrator. 7/21/20, at 1:00 p.m. wing his investigation, he felt clusive because he did not with DSS-X and she had no in her employment file when a further stated he made reach DSS-J and she did not a though QDDP-R told her I dS-X also denied the marized by stating, since he DSS-J and had no concerns, on was inconclusive. R Resolution dated 7/16/20, ated by the director of oak did 7/14/20 to 7/15/20 (no with staff, which concluded with staff, which concluded with staff, which concluded with staff which concluded with staff which has never so she would harm him. | W 1 | 27 | | s. to assure and interview mplete inves do a througe do to comple so the on c for the inve gation check aff immedial determined y | ys for the next 3 tigation should be done in investigion te a fake investiagion all dutities will be stigaions. dist. |
| \$ | some rough handling | me calling such as "brat" and such as turning C20 away | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED C | | |
|---|---|--|---------|--|------------------------------|----------------------------|--|
| | | 24G500 | B. WING | | 07/23/2020 | | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 211 OAK STREET NORTHFIELD, MN 55057 |)DE | | |
| (X4) ID PREFIX TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| W 127 | but could be genth-Interview with HH Oak who stated w frustrated with C20 break, she had co C20 in the past. So not schedule DSS prevent burn-out be challenging/exhaus. A facility e-mail se QDDP-R and directindicated, "An alleverbally threatene of this allegation is was not sustain/pr work as scheduled meet with you Morecommendations internal review." During observation was walking around was walking around was following him room with him. During interview 7 administrator state in reporting and sireported this incided worked at the facilinternal investigat interviewing, QDD more questions we yelled, named callout more informated QDDP-B had received. | not think DSS-X was abusive er when turning him. D-Q (former HHD) at North hen DSS-X was impatient or 0 she would offer to give her a unseled DSS-X about yelling at the further indicated she would -X for multiple days in a row to because C20 can be | W 12 | 27 | | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
|---------------------------------------|---|---|---|---|-------------------------------|----|----------------------------|--|
| | | 24G500 | B. WING | | | | C 23/2020 | |
| | PROVIDER OR SUPPLIER BAKER SERVICES AS | SOCIATION | STREET ADDRESS, CITY, STATE, ZIP CODE 211 OAK STREET NORTHFIELD, MN 55057 | | | | | |
| (X4) ID ⁻ PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD E | 3E | (X5) COMPLETION DATE | |
| | the only one who red DSS-J about the alle enough. The admin following up with QE Review of DSS-X er following: - Employee Discipling 5/17/12, indicated D and violation of polic report indicated it was report further indicated abusive, hostile computations that attended report further indicated internal review of an indicated [DSS-X] must fruit further with the discipline up to an indicated interview with residue to a with the discipline up to an indicated by QDDP-B and QDDP-B's interval into be inconclusive deseveral interviews from the could be rough and we with the properties of the staff | d even though QDDP-R was ceived the interview from egation that should be distrator stated she will be DDP-B. Imployee file indicated the mary Report (EDR) dated SS-X had improper conduct by and procedures. The east written warning. The ed DSS-X was making ments and directives to other aura Baker school with a legation, several persons and legation, several persons and be exhausted and/or behavior and responded by uage that is contrary to respect." The EDR indicated including termination and DSS-X on 7/21/20. Indicated incident 7/13/20, estimate the exhausted and/or behavior and responded by uage that is contrary to respect." The EDR indicated ing and consequence would not including termination and DSS-X on 7/21/20. Indicated incident 7/13/20, estimate the exhausted and/or behavior and responded by uage that is contrary to respect." The EDR indicated ing and consequence would not including termination and DSS-X on 7/21/20. | W 1 | 27 | | | | |
| | In addition, DSS-X w | as allowed to return to work on C20 on 7/21/20 without | | | | | | |

| STATEMENT OF DESCRIPTIONS 24G500 NAME OF PROVIDER OR SUPPLIER LAURA BAKER SERVICES ASSOCIATION SUMMARY STATEMENT OF DESCRIPTIONS (X4) DESCRIPTION OF SUPPLIER LAURA BAKER SERVICES ASSOCIATION SUMMARY STATEMENT OF DESCRIPTIONS (X5) DESCRIPTION OF SUPPLIER LEGALI DEFICIENCY MUST BE PRECEDED TO YPILL RESULATORY OR LSC DIDINIFYMS INFORMATION W 127 Continued From page 6 adequate retraining of the abuse policy and procedure, without supervision and monitoring of her performance and interaction with clients and without adequate monitoring or enforcement of recommendation to ensure DSS-X was not be allowed to work excessive hours with C2. During interview 7/22/20, at 10.30 a.m. the director of oak services confirmed DSS-X was receiving training on vulnerable adult abuse and neglect policies today and a monitoring system was developed by management to ensure adequate oversight of her work hours and interacations with C20. The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 697/2020, indicated any employee or volunteer with nas 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 manadated 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 appropriete, removing the alleged victim. 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 | CENTERS FOR MEDICARE & MEDICARD SERVICES | | | | (X3) DATE SURVEY | | | | |
|--|--|---|--|----------|------------------|--|-----------|------------|--|
| NAME OF PROVIDER OR SUPPLIER LAURA BAKER SERVICES ASSOCIATION CA ID PRIEFIX DANK STREET PROVIDERS PLAN OF CORRECTION PRIEFIX PROVIDERS PLAN OF C | STATEMENT C | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | | COMPLETED | | |
| NAME OF PROVIDER OR SUPPLIER LAURA BAKER SERVICES ASSOCIATION PROPRIETIX TAG W 127 Continued From page 6 adequate retraining of the abuse policy and procedure, without adequate monitoring or enforcement of recommendation to ensure DSS-X was not be allowed to work excessive hours with C2. During interview 7/22/20, at 10:30 a.m. the director of oak services confirmed DSS-X was not be allowed to work excessive hours with C2. The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 57/2020, indicated any employee or volunteer who has reason to believe a vulnerable adult or minor is being or has been maltreaded must report it immediately. When the mandated reporter has reason to believe a vulnerable adult or minor is being or has been maltreaded must report at immediately. When the mandated reporter has reason to believe a vulnerable adult or minor is being or has been maltreaded must report at immediately. When the mandated reporter has reason to believe a vulnerable report make and have appropriate supervision. In addition the report indicated the program's mandated reporter or designee shall actions to insure the safety of the vulnerable person, including, as appropriate, removing the alleged victim. W 153 STAFF TREATMENT OF CLIENTS CFR, 383-480(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 | AND PLAN OF | CORRECTION | IDENTIFICATION ROBBER. | A. BUILL | JING _ | | | : | |
| INMIE OF PROVIDER OR SUPPLIER LAURA BAKER SERVICES ASSOCIATION 21 OAK STREET NORTHFIELD, MN 56057 SUMANNY STATEMINT OF DEFICIENCIES (EACH DEFICIENCY MUST EE PRECEDED BY PULL (EACH DEFICIENCY AFROPHIATE W 127 Continued From page 6 adequate retraining of the abuse policy and procedure, without supervision and monitoring of her performance and interaction with clients and without adequate monitoring or enforcement of recommendation to ensure DSS-X was not be allowed to work excessive hours with C2. During interview 7722/20, at 10:30 a.m. the director of cake services confirmed DSS-X was receiving training on vulnerable adult abuse and neglect policies today and a monitoring system was developed by management to ensure adequate oversight of her work hours and interacetions with C20. The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 57//2020, 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 reporter or designee shall be responsible for reviewing and investigating the report, and directing or taking any and all actions to insure the safely of the vulnerable person, including, as appropriate, removing the alleged perpetrator from direct contact with the alleged victim. W 153 STAFF TREATMENT OF CLIENTS CFR(S): 483-49(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 | | | 24G500 | B. WING | | | 07/2 | 3/2020 | |
| LAURA BAKER SERVICES ASSOCIATION 2(A4) ID FREERIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS TAGS COntinued From page 6 adequate retraining of the abuse policy and procedure, without supervision and monitoring of her performance and interaction with clients and without adequate monitoring or enforcement of recommendation to ensure DSS-X was not be allowed to work excessive hours with C2. During interview 7/22/20, at 10:30 a.m. the director of oak services confirmed DSS-X was not be allowed to work excessive hours with C2. During interview 7/22/20, at 10:30 a.m. the director of oak services confirmed DSS-X was not be allowed to work excessive hours with C2. The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 57/2020, 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 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. W 153 STAFF TREATMENT OF CLIENTS CFG): 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 | NAME OF DE | OVIDED OR SUPPLIER | 2.000 | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| SUMMARY STATEMENT OF DEFICIENCIES CRACH DEFICIENCY MISST BE PRECEDED BY FULL FREE PROVIDERS RLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | | | | | | | | |
| W 127 Continued From page 6 adequate retraining of the abuse policy and procedure, without supervision and monitoring of her performance and interaction with clients and without adequate monitoring or enforcement of recommendation to ensure DSS-X was receiving training on vulnerable adult abuse and neglect policies today and a monitoring system was developed by management to ensure adequate oversight of her work hours and interactions. A service of the Prevention & Reporting of Individual Maltreatment revised 57/12020, 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 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. W 153 STAFT TREATIMENT OF CLIENTS Cref(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 | LAURA BA | AKER SERVICES AS | SSOCIATION | | N | | | | |
| adequate retraining of the abuse policy and procedure, without supervision and monitoring of her performance and interaction with clients and without adequate monitoring or enforcement of recommendation to ensure DSS-X was not be allowed to work excessive hours with C2. During interview 7/22/20, at 10:30 a.m. the director of oak services confirmed DSS-X was receiving training on vulnerable adult abuse and neglect policies today and a monitoring system was developed by management to ensure adequate oversight of her work hours and interacations with C20. The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 67/72020, 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 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 victim. W 153 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 | PRÉFIX | /EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF | D BE | COMPLETION | |
| Prevention & Reporting of Individual Maltreatment revised 577/2020, 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 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. W 153 W 153 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 | | adequate retraining procedure, without her performance a without adequate recommendation to allowed to work ex During interview 7 director of oak ser receiving training on eglect policies to was developed by adequate oversight | g of the abuse policy and supervision and monitoring of nd interaction with clients and monitoring or enforcement of censure DSS-X was not be cessive hours with C2. 22/20, at 10:30 a.m. the vices confirmed DSS-X was on vulnerable adult abuse and day and a monitoring system management to ensure it of her work hours and | W | 127 | | | | |
| 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 | W 153 | Prevention & Reporevised 5/7/2020, volunteer who has adult or minor is be must report it immore reporter has reast be made, he/she and have appropring report indicated the or designee shall and investigating taking any and all the vulnerable peremoving the allegentact with the a STAFF TREATME | orting of Individual Maltreatment indicated any employee or reason to believe a vulnerable eing or has been maltreated rediately. When the mandated on to believe a report needs to must ensure clients are safe report in addition the reportam's mandated reporter be responsible for reviewing the report, and directing or actions to insure the safety of rson, including, as appropriate, ged perpetrator from direct lleged victim. | | <i>l</i> 153 | 3 | | | |
| 16 - entire enti | | mistreatment, ne | glect or abuse, as well as yn source, are reported | | | see above | | | |

| | AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | | 24G500 | B. WING | | | С | |
| | | PROVIDER OR SUPPLIER BAKER SERVICES AS | SOCIATION | | STREET ADDRESS, CITY, STATE, ZIP C 211 OAK STREET NORTHFIELD, MN 55057 | ODE | 07/23/2020 | |
| | (X4) ID PREFIX TAG | (EACH DEFICIENCY | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A | SHOULD BE | (X5) COMPLETIO DATE | N |
| | W 153 | Continued From page officials in accordance established procedur. This STANDARD is Based on interview facility failed to immediadministrator and state (C20) alleged to have findings include: C20's Emergency Day 7/21/20, indicated he a diagnosis of profour anxiety and panic attaindicated he was non C20's Individual Abust added 2/26/20, indicated himself from a abusing during all waking house on the staff will be rotated pendicated he does not be moved himself from a corocedure. Further the staff will be rotated pendicated he does not be moved himself from a corocedure of the staff. A Common Entry Representation of the pendicated he does not be moved in the staff. A Common Entry Representation of the pendicated he does not be moved in the staff. A Common Entry Representation of the pendicated he does not be moved in the pendicated he does not be pe | ce with State law through res. not met as evidenced by: and document review, the ediately contact the ate agency for 1 of 1 clients re been verbally abused. ata Form (EDF) dated admitted on 7/11/1980 with not intellectual disability, acks. In addition the form -verbal. See Prevention Plan (IAPP) ted he would not remove re situation, and has 1:1 staff rs with the exception of 10 redirect from abusive et rained to monitor for the internal reporting the IAPP indicated his 1:1 er shift. Lastly the IAPP acknowledge needing to a area of physically or erson thus needs 1:1 with cort (CEP) dated 7/13/20, developmental disability R, indicated "On Monday, old director where IC20I | W 15 | CROSS-REFERENCED TO THE A | ays will be revien and immedian and immedian administrator eatment alligat | ewed ately | |
| _ | h | iad reported some ve | nat a previous staff (DSS-J) rbal threats directed other staff person. The | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION | COM | E SURVEY IPLETED C |
|--|---|--------------------|--|-----------------------------------|----------------------------|
| | 24G500 | B. WING | | 07/ | 23/2020 |
| NAME OF PROVIDER OR SUPPLIER LAURA BAKER SERVICES AS | SSOCIATION | | STREET ADDRESS, CITY, STATE, Z 211 OAK STREET NORTHFIELD, MN 55057 | IP CODE | |
| (FACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| support staff [DSS-teeth" or "break [CZ reporting said that [DSS-X] and [DSS-that she would "break further went on to i DSS-X and poking kept doing that she A General Events F 7/17/20, indicated previous staff) and C20 and she did not feel DSS-X woo QDDP-B (facility previous facility previous or reply the report indicated made to contact all in the last 30 days threats to C20. Laclosed by the facility The report did not conclusion was but administrator. During interview 7/QDDP-R who state allegation and calles she said yes and seincident to the state QDDP-R knew was sometime afte worked here just as sincident enter the state QDDP-R knew was sometime after worked here just as sincident enter the state QDDP-R knew was sometime after worked here just as sincident enter the state QDDP-R knew was sometime after worked here just as sincident enter the state QDDP-R knew was sometime after th | age 8 aid that she heard direct -X] threaten to "break [C20]'s 20]'s fingers." The person during the incident, [C20] bit -X] told [C20] if he kept doing eak his teeth". The report indicate C20 kept pointing at at her and she told him if he e would break his fingers. Resolution (GER) dated QDDP-R contacted DSS-J (the she stated DSS-X threatened of report this because she did uld follow through with it. rogram mandated reporter) ict DSS-J multiple times to ions and she did not answer to voice mails. Furthermore d by QDDP-B an attempt was I staff who worked with DSS-X and no staff could confirm any estly this report indicted it was ty administrator on 7/17/20. indicate what QDDP-B's t was signed by the 1/21/20 at 9:30 a.m. with ed she was informed of the all ed DSS-J to see it was true and estated she did not report the te or the facility administrator. SS-J was unsure the exact date of the started after COVID so it are March 2020 and she only are few months. QDDP-R then of the incident who notified the | | 153 | | |

| STATEMEN AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | |
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| | | 24G500 | B. WING | | 0. | C | |
| NAME OF | PROVIDER OR SUPPLIER | | <u>'</u> | STREET ADDRESS, CITY, STATE, ZIP CODE | 01 | 7/23/2020 | |
| LAUDA | DAVED CEDVICES AS | 2001471011 | 1 | 211 OAK STREET | | | |
| LAUKA | BAKER SERVICES AS | SOCIATION | | NORTHFIELD, MN 55057 | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORREC | LION | (X5) | |
| PREFIX TAG | REGULATORY OR LS | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI) TAG | X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | II D RE | COMPLETION DATE | |
| W 153 | Continued From page | ge 9 | W 1 | 53 | | | |
| W 154 | The facility Policy & Prevention & Reporrevised 5/7/2020, involunteer who has readult or minor is being must report it immediate and have approaddition the policy in must be notified. STAFF TREATMENT CFR(s): 483.420(d)() The facility must have violations are thorout abused on interview facility failed to thorout facility failed to thorout facility failed to thorout abuse for 1 of 1 cl to client abuse. Findings include: C20's Emergency Date of 1/21/20, indicated he a diagnosis of profour anxiety and panic attendicated he was not revolved. | Procedures for the ting of Individual Maltreatment dicated any employee or eason to believe a vulnerable ng or has been maltreated diately and ensure clients are opriate supervision. In edicated the administrator T OF CLIENTS (3) We evidence that all alleged ghly investigated. Interpretation of the process of the proc | W 1 | | completed iinistrator QDDPs rmine | etor 9/23/20 | |
| | dated 2/26/20, indica himself from a abusiv during all waking hou p.m. to 6:30 a.m. and | se Prevention Plan (IAPP) ted he would not remove we situation, and has 1:1 staff ars with the exception of 10 d redirect from abusive re trained to monitor for the internal reporting | | | | | |
| | | | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 24G500 | B. WING | | | 1 | 23/2020 |
| | PROVIDER OR SUPPLIER BAKER SERVICES A | | - | 21 | REET ADDRESS, CITY, STATE, ZIP CODE 1 OAK STREET ORTHFIELD, MN 55057 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| W 154 | staff will be rotated indicated he does remove himself fro verbally aggressive staff. | age 10 If the IAPP indicated his 1:1 If per shift. Lastly the IAPP not acknowledge needing to a area of physically or a person thus needs 1:1 with | W. | 154 | see above | | |
| | reported by qualific professional (QDD July 13th, the hous lives notified QDD had reported some towards [C20] from person reporting s support staff [DSS teeth" or "break [C reporting said that [DSS-X] and [DSS that she would "brefurther went on to DSS-X and poking | Report (CEP) dated 7/13/20, ed developmental disability P)-R, indicated "On Monday, sehold director where [C20] P, that a previous staff (DSS-J) e verbal threats directed in another staff person. The aid that she heard direct -X] threaten to "break [C20]'s 20]'s fingers." The person during the incident, [C20] bit -X] told [C20] if he kept doing eak his teeth". The report indicate C20 kept pointing at a ther and she told him if he e would break his fingers. | | | | | |
| | 7/17/20, indicated previous staff) and C20 and she did not feel DSS-X wo QDDP-B (facility pattempted to conform the allega her phone or reply the report indicate made to contact a in the last 30 days could not confirm report indicated it works. | Resolution (GER) dated QDDP-R contacted DSS-J (the I she stated DSS-X threatened of report this because she did ould follow through with it. For act DSS-J multiple times to tions and she did not answer to voice mails. Furthermore d by QDDP-B an attempt was and staff who worked with DSS-X and staff who are employees any threats to C20. Lastly this was closed by the facility 1/17/20. The report did not | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | 1 '7 ' | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 24G500 | B. WING | ì | | 1 | С |
| | PROVIDER OR SUPPLIER | | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 211 OAK STREET NORTHFIELD, MN 55057 | <u> 07</u> | /23/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | indicate what QDDF report was signed by During interview 7/2 stated he felt the report was signed by During interview 7/2 stated he felt the report was a signed by DSS-X and had not employee file when stated he made multiand she did not reture QDDP-R told her he also denied the alleghe did hear back from concerns he felt the inconclusive. Furthed did not interview the had no explanation at that as part of his property of the p | P-B's conclusion was but the by the administrator. 21/20 at 1:00 p.m. QDDP-B port was inconclusive have any problems with disciplinary actions in her he looked today. He further tiple attempts to reach DSS-J rn his calls even though would be calling. DSS-X gations. He then stated since im DSS-J and had no investigation was ermore QDDP-B stated he other clients in the home and as to why he did not include ocess. 2 Resolution dated 7/16/20, lated by the director of oak cated QDDP-B had several 4/20 to 7/15/20 with no times, cluded the following: -P stated DSS-X has a loud e. Y stated she has heard ime calling such as "brat" and g such as turning C20 away of this DSS-X was abusive when turning him. X stated she has never 20 she would harm him. Q (former HHD)at North in DSS-X was impatient or the would offer to give her a | W | 54 | | | |
| | some rough handling from door. But did no but could be gentler -Interview with DSS-threatened or told C2-Interview with HHD-Oak who stated whe frustrated with C20 s break, she had coun | g such as turning C20 away of this DSS-X was abusive when turning him. X stated she has never 20 she would harm him. Q (former HHD)at North n DSS-X was impatient or | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|---|---|--|-------------------------------|----------------------------|--|
| | | 24G500 | B. WING_ | | I . | C 23/2020 | |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 211 OAK STREET NORTHFIELD, MN 55057 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | |
| W 154 | Despite having severating DSS-X was clients, and was obsuch as "brat", as well previous concerns supervisor of her d QDDP-B's determinabuse due to being himself (even though interviewed and recabuse and physical because there was recorded in DSS-X more QDDP-B failed investigation when regarding aggressi interviews gathered when QDDP-B failed of the internal investigation when reporting the incident the MAARC [Minner Center] the program begin the internal investigation included in this polimpartial investigation and policies and proced whether or not they need for additional policy indicated "If | X for multiple days in a row to ecause C20 can be sting. Feral interviews from staff loud, could be rough with oserved calling clients names well as gaining a history of from her previous house irect behavior towards C20, nation was inconclusive to gunable to contact DSS-J gh QDDP-R had already ceived her report of the verbal I threat made by DSS-X) and a not any history of concerns its employee file. Further ed to complete a thorough he did not inquire further ve behavior reported during diduring the investigation and ed to interview clients as part | W 18 | 54 | | | |
| | \mid is a threat to the al | leged victim or others." | | | | | |

| STATEMENT AND PLAN (| T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|------------------------------------|---|--|----------|---|-------------------------------|----------------------------|
| | | 24G500 | B. WING | | | C | |
| | PROVIDER OR SUPPLIER | | | S' 2' | TREET ADDRESS, CITY, STATE, ZIP CODE 11 OAK STREET IORTHFIELD, MN 55057 | <u> 07/</u> | 23/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email November 12, 2020

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

RE: Event ID: X1CR12

Dear Administator:

On October 2, 2020, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with Conditions of Participation (CoP) pursuant to a fundamental survey, completed on July 23, 2020. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our PCR, we have determined that your facility has corrected Conditions of Participation (CoP) pursuant to our survey, completed on July 23, 2020.

The following Conditions of Participation (CoP) was found corrected at the time of the PCR:

W-0122 Client Protection 42 CFR 483.420

At the time of the revisit a deficiency was reissued.

W0153 - Staff Treatment of Clients

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

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

- 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

Laura Baker Services Association

Page 2

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:

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

Laura Baker Services Association

Page 3

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,

Any Johour

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

PRINTED: 11/12/2020 FORM APPROVED OMB NO. 0938-0391

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--------------------|-----|---|-------------------------------|----------------------------|
| | | 0.40500 | | | · | | -C |
| | | 24G500 | B. WING | | | 10/ | 02/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAURA E | BAKER SERVICES AS | SSOCIATION | | | 211 OAK STREET NORTHFIELD, MN 55057 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| {W 000} | INITIAL COMMEN | TS | {W 0 | 00} | } | | |
| {W 153} | Department of Headeficiencies issued exited 7/23/20. The in compliance with 483. Subpart I, for Individuals with Inte STAFF TREATMEN CFR(s): 483.420(d) The facility must en mistreatment, neglinjuries of unknown immediately to the | y a surveyor of the Minnesota alth to follow-up on the during an abbreviated survey a facility was NOT found to be the requirements of 42 CFR Intermediate Care Facilities for allectual Disabilities (ICF/IID.) NT OF CLIENTS (ICF) (2) Insure that all allegations of ect or abuse, as well as a source, are reported administrator or to other nice with State law through | {W 1 | 53} | } | | |
| | Based on interview facility failed to ens reported immediate administrator and s involving 5 of 5 clie reviewed for abuse Findings include: C5's Emergency Da 10/1/20, indicated (19) | s not met as evidenced by: v and document review, the ure allegations of abuse were ely within 2 hours to the state agency for 4 incidents ints (C5, C6, C7, C8, C9) ata Form (EDF) generated C5's diagnoses included disabilities, autistic disorder, | | | | | |
| | attention deficit hyp convulsions. | peractivity disorder, and see Prevention Plan (IAPP) | | | | | |
| LABORATOR' | Y DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIGI | NATURE | | TITLE | | (X6) DATE |

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

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | COMPLETED R-C | | |
|--|--|--|---------------------|---|---------------|----------------------------|--|
| | | 24G500 | B. WING | | | /02/2020 | |
| | PROVIDER OR SUPPLIER BAKER SERVICES AS | SSOCIATION | | STREET ADDRESS, CITY, STATE, ZIP CODE 211 OAK STREET NORTHFIELD, MN 55057 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| {W 153} | dated 5/29/20, had potentially dangero being abused and I others by swearing staff were to be present to be presen | an inability to identify us situations, was at risk for had the potential to abuse, hitting or kicking others, and issent when not in his bedroom. Fort Plan (BSP) dated 4/24/20, but behaviors included physical others including hitting and verbal aggression. C5's BSP riggers for behaviors and tips behaviors, including assisting following a set routine. In d 10/1/20, indicated C6's all generalized anxiety disorder, we disorder, and profound by a physical aggression and fing, pulling hair or clothes to a ground, which could be clients in the household. C6's scribed and indicated staff or essent at all times when she is | | 3} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--------------------|----------------|--|-----|----------------------------|
| | | 24G500 | B. WING | | | | -C 02/2020 |
| | PROVIDER OR SUPPLIER | | | S ⁻ | TREET ADDRESS, CITY, STATE, ZIP CODE 11 OAK STREET IORTHFIELD, MN 55057 | 10/ | 02/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| {W 153} | close to her or invainterventions included peers out of her respective of her respective of transitions. C7's EDF generated diagnoses included disability, anxiety of hyperactivity disord. C7's IAPP dated 2/for being abused a aggressive toward others, such as he would hug them had individual into walls to have one-to-one hours with the excessivities, avoid commore people, and provided aggression spitting at others in usually when not fee something, or does target behaviors in and physical aggreguest or randomly. One-to-one staff whareas, block attern in his room. | ding her space, and led staff to attempt to keep her ach and place themselves eers, especially during stressful and 10/2/20, indicated C7's approfound intellectual isorder, attention deficit ler, and panic disorder. 26/20, indicated C7 was at risk and had a history of being others by randomly hitting passed them in hallways, or and enough to slam the targeted or knock them down. C7 was staffing during all awake eption of 10 p.m. to 6:30 a.m., and redirect to other and redirect to other and redirect to other operated areas, or areas with provide verbal redirection. Port Plan dated 2/27/18, used a such as hitting others or an attempt to communicate, eeling well, does not want to do a not like something. C7's cluded panic attacks, spitting, ssion which can happen when Staff were to provide out to the other of the such as to avoid congested outs to hit others, suggest time | | 53} | | | |
| | diagnoses included | ed 10/2/20, indicated C8's If a moderate intellectual nittent explosive disorder. | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|--|--|----------------------|-----|--|------|----------------------------|
| | | 24G500 | B. WING | | | | -C 02/2020 |
| | PROVIDER OR SUPPLIER | SSOCIATION | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 11 OAK STREET IORTHFIELD, MN 55057 | 10/1 | 0212020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T | BE | (X5) COMPLETION DATE |
| {W 153} | C8's IAPP dated 7/for being abused a physically and verb was to have goals inappropriate beha on every 15 minute awake, and every 6 C8's BSP target be such as hitting, kick objects, or choking reinforcement/rewalnterventions include appropriate activity aggression. C9's EDF generated diagnoses included intermittent explosi intellectual disability. C9's IAPP dated 7/for being abused, a appropriate boundated such as hugging and be supervised at he provide verbal rediing on every 15 minute awake, and every 15 minute awake, and every 15 staff were to interval aggression from an C9's BSP dated 7/for behaviors included trigger of frustration staff were to redire | /27/20, indicated C8 was at risk and had a history of being pally aggressive to others. C8 to work on decreasing viors and was to be checked as when alone in her room and 60 minutes when sleeping. The haviors included aggression, king, hair pulling, throwing and was on a fard system program. The ded redirection to a more without giving attention for a personality disorder, and severe by. In 10/20, indicated C9 was at risk and lacked understanding of aries and displayed behaviors and kissing others. C9 was to be checked as when in his room and mour when asleep. In addition, ene when C9 was dealing with | {W 15 | 53} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|------------------------|---|-----------|----------------------------|
| | | 24G500 | B. WING | | | R-C / /02/2020 |
| | PROVIDER OR SUPPLIER | SOCIATION | | STREET ADDRESS, CITY, STATE, ZIP CO 211 OAK STREET NORTHFIELD, MN 55057 | | 70272020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| {W 153} | 8/23/20, at 7:50 p.n and dug nails into 0 A CEP dated 9/18/2 9/17/20, at approximation C6 exited her living room, turned and pulled on him. and C5 left the area incident was not repared. By the qualifier professional (QDDI) A General Event Redated 9/17/20, indicated 9/17/20, indicated GDDP-C the incident at the transition of the reviewed and report on 9/18/20, at 12:50 A CEP report dated on 9/22/20, at approved the incident at the transition of the reviewed and report on 9/18/20, at 12:50 A CEP report dated on 9/22/20, at approved to a different sofa a indicated the incided 9/22/20, at 1:50 p.n. A GER dated 9/22/20, head at 10:30 a.m. | m., indicated an incident on in. occurred when C8 grabbed C7's arm. 20, indicated an incident on mately 3:20 p.m. occurred bedroom, walked into the and grabbed C5 by the shirt C5 and C6 were separated a. The CEP indicated the ported until 9/18/20, at 11:15 developmental disability C9)-C. Exports (GER) for an incident cated at 3:20 p.m. C5 was pulled off the sofa. C5 agernail scratches on his neck led by his collar. The GER was present and responded to the ime of occurrence. QDDP-C and GER, that the report was ted to the state agency (SA) 4 p.m. 19/22/20, indicated an incident eximately 10:30 a.m. occurred apset with staff when a request at C7 slapped C9 on the top of ime upset, and staff moved C7 and stayed with him. The CEP int was not reported until in. by the QDDP-C. 20, indicated C7 hit C9 on the when C7 was upset when he or staff to assist him before | {W 15 | 53} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | FIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|------------------------|---|-------------|----------------------------|
| | | 24G500 | B. WING | | | R-C 2 /02/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 211 OAK STREET NORTHFIELD, MN 55057 | • | 70212020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE |
| {W 153} | A CEP report dated on 10/1/20, at appropriate to the SA A GER dated 10/1/10/1/20, at 4:30 p. hall and slapped C Staff intervened to GER indicated QD reporter, was not in On 10/2/20, at 10:5 developmental dissistated when he hapotential abuse alleas possible, within did not know he way QDDP-C stated stated when he hapotential abuse alleas possible, within did not know he way QDDP-C stated he aggression toward report it until the nethought it was report | d 10/1/20, indicated an incident roximately 4:50 p.m. occurred C9 on the back as he walked indicated the incident was not until 9:45 p.m. 20, indicated an incident on m. C7 was walking down the 9 on the back as he walked by separate C7 and C9. The DP-C, the facility mandated otified until 8:30 p.m. | {W 15 | 53} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---|---|---|-------------------------------|--|
| | | 24G500 | B. WING | | | R-C / 02/2020 | |
| NAME OF PROVIDER OR SUPPLIER LAURA BAKER SERVICES ASSOCIATION | | | | STREET ADDRESS, CITY, STATE, ZI 211 OAK STREET NORTHFIELD, MN 55057 | | 102/2020 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE | | |
| {W 153} | the state agency. It trained staff to repountil the end of the The facility Policy & Prevention & Reportevised 5/7/2020, in volunteer who has a adult or minor is be must report it immesafe and have approximation of the state o | en be reported immediately to DOS-TT stated they had rt right away and not to wait shift. | {W 1 | 53} | | | |