



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:

Laura Baker Services Association

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

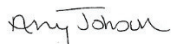
Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

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,



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
Event 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,

A handwritten signature in black ink that reads 'Amy Johnson'.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2020
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
5 000	<p>Initial Comments</p> <p>In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 7/21/20 through 7/23/20, an abbreviated survey was completed to investigate complaint HG500056C and HG500059C. The complaints were found to be substantiated. No licensing orders were issued. Your facility is in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).</p>	5 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G500	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/23/2020
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W 000	INITIAL COMMENTS On 7/21/20 through 7/23/20, 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). In addition, the Condition of Participation: Client Protection 42 CFR 483.420 found not met. HG500056C was substantiated with deficiencies issued at W122, W127, HG500059C was substantiated with no deficiencies issued. As a result of the complaint investigations deficiencies were also identified at W153 and W154.	W 000			
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed to protect a client who was being verbally abused by a staff member that was not immediately reported or protected for 1 of 1 clients (C20) reviewed for abuse.	W 122			

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

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	Continued From page 1 Findings include: See W127: The facility failed to protect a client from verbal abuse from staff for 1 of 1 clients (C20) reviewed for abuse.	W 122			
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to protect a client from abuse when a staff member was alleged to make verbal threats to hurt a client for 1 of 1 clients (C20) reviewed for abuse. Findings include: C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980. The EDF further indicated he had profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal. C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP	W 127			

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W 127	<p>Continued From page 2</p> <p>indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff.</p> <p>A Common Entry Report (CEP) dated 7/13/20, 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.</p> <p>A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore, the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and staff who are employees could not confirm any threats to C20. The report did not indicate what QDDP-B's conclusion was but the report was closed and signed by the administrator on 7/17/20.</p>	W 127			

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W 127	<p>Continued From page 3</p> <p>During interview on 7/21/20, at 9:30 a.m. with QDDP-R who stated she was informed of the allegation and called DSS-J to confirm if the allegation was true, adding DSS-J confirmed she had witnessed the verbal abuse and that DSS-J had not reported the allegation as required because she did not think DSS-X would actually hurt C20. C20 was unable to provide a specific date. QDDP-R stated she then notified QDDP-B of the incident who notified the administrator.</p> <p>During interview on 7/21/20, at 1:00 p.m. QDDP-B stated following his investigation, he felt the report was inconclusive because he did not have any problems with DSS-X and she had no disciplinary actions in her employment file when he looked today. He further stated he made multiple attempts to reach DSS-J and she did not return his calls, even though QDDP-R told her I would be calling. DSS-X also denied the allegations. He summarized by stating, since he did hear back from DSS-J and had no concerns, he felt the investigation was inconclusive.</p> <p>An addition, the GER Resolution dated 7/16/20, at 1:29 p.m. last updated by the director of oak street services (DOCS), indicated QDDP-B had several interviews dated 7/14/20 to 7/15/20 (no times documented) with staff, which concluded the following:</p> <ul style="list-style-type: none"> -Interview with DSS-X stated she has never threatened or told C20 she would harm him. -Interview with HHD-P stated DSS-X has a loud and demanding voice. -Interview with DSS-Y stated she had heard DSS-X use some name calling such as "brat" and some rough handling such as turning C20 away 	W 127			

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W 127	<p>Continued From page 4</p> <p>from door. But did not think DSS-X was abusive but could be gentler when turning him.</p> <p>-Interview with HHD-Q (former HHD) at North Oak who stated when DSS-X was impatient or frustrated with C20 she would offer to give her a break, she had counseled DSS-X about yelling at C20 in the past. She further indicated she would not schedule DSS-X for multiple days in a row to prevent burn-out because C20 can be challenging/exhausting.</p> <p>A facility e-mail sent from QDDP-B to DSS-X, QDDP-R and director of oak creek services indicated, "An allegation was made that you verbally threatened a client. The internal review of this allegation is inconclusive and allegation was not sustain/proven. You are able to report to work as scheduled on Monday 7/20/20. I want to meet with you Monday morning to discuss recommendations I have made as a result of the internal review."</p> <p>During observation 7/22/20, at 10:00 a.m. C20 was walking around in North Oak house. DSS-X was following him around going from room to room with him.</p> <p>During interview 7/22/20, at 10:15 a.m. the facility administrator stated DSS-J had received training in reporting and should have immediately reported this incident to us (DSS-J no longer worked at the facility). In addition, after reviewing internal investigation notes, she stated while interviewing, QDDP-B should have asked staff more questions when they stated DSS-X had yelled, named called or was being rough to find out more information. Further more, she stated QDDP-B had received training in the past about keeping a open mind in his decisions while doing</p>	W 127			

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W 127	<p>Continued From page 5</p> <p>his investigation and even though QDDP-R was the only one who received the interview from DSS-J about the allegation that should be enough. The administrator stated she will be following up with QDDP-B.</p> <p>Review of DSS-X employee file indicated the following:</p> <ul style="list-style-type: none"> - Employee Disciplinary Report (EDR) dated 5/17/12, indicated DSS-X had improper conduct and violation of policy and procedures. The report indicated it was written warning. The report further indicated DSS-X was making abusive, hostile comments and directives to other staff and students (Laura Baker school with clients that attended). -EDR dated 7/20/20, indicated incident 7/13/20, inappropriate interactions with clients. "During an internal review of an allegation, several persons indicated [DSS-X] may be exhausted and/or frustrated with client behavior and responded by yelling or using language that is contrary to treating clients with respect." The EDR indicated it was a written warning and consequence would be discipline up to and including termination signed by QDDP-B and DSS-X on 7/21/20. <p>QDDP-B's interval investigation was determined to be inconclusive despite having interviews from several interviews from staff stating she was loud, could be rough and was name calling, Furthermore, QDDP-B failed to asked additional questions of the staff when information was provided regarding potential rough handling and verbal abuse of clients by DSS-X. In addition, DSS-X was allowed to return to work and work directly with C20 on 7/21/20 without</p>	W 127			

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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 interactions with C2. The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 5/7/2020, 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 127			
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	W 153			

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W 153	<p>Continued From page 7</p> <p>officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately contact the administrator and state agency for 1 of 1 clients (C20) alleged to have been verbally abused.</p> <p>Findings include:</p> <p>C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980 with a diagnosis of profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal.</p> <p>C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff.</p> <p>A Common Entry Report (CEP) dated 7/13/20, 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</p>	W 153			

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W 153	<p>Continued From page 8</p> <p>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.</p> <p>A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and no staff could confirm any threats to C20. Lastly this report indicted it was closed by the facility administrator on 7/17/20. The report did not indicate what QDDP-B's conclusion was but was signed by the administrator.</p> <p>During interview 7/21/20 at 9:30 a.m. with QDDP-R who stated she was informed of the all allegation and called DSS-J to see it was true and she said yes and stated she did not report the incident to the state or the facility administrator. QDDP-R stated DSS-J was unsure the exact date but QDDP-R knew she started after COVID so it was sometime after March 2020 and she only worked here just a few months. QDDP-R then notified QDDP-B of the incident who notified the administrator.</p>	W 153			

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W 153	Continued From page 9	W 153			
W 154	<p>The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 5/7/2020, 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 and ensure clients are safe and have appropriate supervision. In addition the policy indicated the administrator must be notified.</p> <p>STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate allegations of abuse for 1 of 1 client (C20) reviewed for staff to client abuse.</p> <p>Findings include:</p> <p>C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980 with a diagnosis of profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal.</p> <p>C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting</p>	W 154			

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W 154	<p>Continued From page 10</p> <p>procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff.</p> <p>A Common Entry Report (CEP) dated 7/13/20, 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.</p> <p>A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and staff who are employees could not confirm any threats to C20. Lastly this report indicted it was closed by the facility administrator on 7/17/20. The report did not</p>	W 154			

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W 154	<p>Continued From page 11 indicate what QDDP-B's conclusion was but the report was signed by the administrator.</p> <p>During interview 7/21/20 at 1:00 p.m. QDDP-B stated he felt the report was inconclusive because he did not have any problems with DSS-X and had no disciplinary actions in her employee file when he looked today. He further stated he made multiple attempts to reach DSS-J and she did not return his calls even though QDDP-R told her he would be calling. DSS-X also denied the allegations. He then stated since he did hear back from DSS-J and had no concerns he felt the investigation was inconclusive. Furthermore QDDP-B stated he did not interview the other clients in the home and had no explanation as to why he did not include that as part of his process.</p> <p>An addition, the GER Resolution dated 7/16/20, at 1:29 p.m. last updated by the director of oak street services, indicated QDDP-B had several interviews dated 7/14/20 to 7/15/20 with no times, with staff which concluded the following:</p> <ul style="list-style-type: none"> -Interview with HHD-P stated DSS-X has a loud and demanding voice. -Interview with DSS-Y stated she has heard DSS-X use some name calling such as "brat" and some rough handling such as turning C20 away from door. But did not this DSS-X was abusive but could be gentler when turning him. -Interview with DSS-X stated she has never threatened or told C20 she would harm him. -Interview with HHD-Q (former HHD)at North Oak who stated when DSS-X was impatient or frustrated with C20 she would offer to give her a break, she had counseled DSS-X about yelling at C20 in the past. She further indicated she would 	W 154			

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W 154	<p>Continued From page 12</p> <p>not schedule DSS-X for multiple days in a row to prevent burn-out because C20 can be challenging/exhausting.</p> <p>Despite having several interviews from staff stating DSS-X was loud, could be rough with clients, and was observed calling clients names such as "brat", as well as gaining a history of previous concerns from her previous house supervisor of her direct behavior towards C20, QDDP-B's determination was inconclusive to abuse due to being unable to contact DSS-J himself (even though QDDP-R had already interviewed and received her report of the verbal abuse and physical threat made by DSS-X) and because there was not any history of concerns recorded in DSS-X's employee file. Further more QDDP-B failed to complete a thorough investigation when he did not inquire further regarding aggressive behavior reported during interviews gathered during the investigation and when QDDP-B failed to interview clients as part of the internal investigation.</p> <p>A facility policy revised 5/7/20, indicated 5. After reporting the incident of alleged abuse/neglect to the MAARC [Minnesota Adult Abuse Reporting Center] the programs mandated reporter will begin the internal investigation. The program reporter is responsible for using the checklists included in this policy for conducting a fair and impartial investigation. The internal review will also include an evaluation of whether related policies and procedures were followed and whether or not they were adequate, if there is a 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."</p>	W 154			

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W 000	<p>INITIAL COMMENTS</p> <p>On 7/21/20 through 7/23/20, 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/IID).</p> <p>In addition, the Condition of Participation: Client Protection 42 CFR 483.420 found not met.</p> <p>HG500056C was substantiated with deficiencies issued at W122, W127,</p> <p>HG500059C was substantiated with no deficiencies issued.</p> <p>As a result of the complaint investigations deficiencies were also identified at W153 and W154.</p>	W 000		
W 122	<p>CLIENT PROTECTIONS CFR(s): 483.420</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed to protect a client who was being verbally abused by a staff member that was not immediately reported or protected for 1 of 1 clients (C20) reviewed for abuse.</p>	W 122		

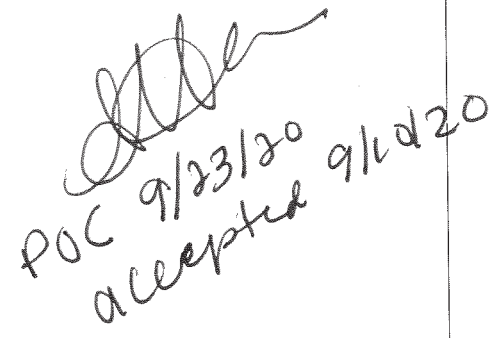
*Shelley
PIC 9/23/20
accepted 9/10/20*

DIRECTOR, CLINICAL SERVICES OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Facility Administrator* (X6) DATE: *8/22/20*

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 000	INITIAL COMMENTS On 7/21/20 through 7/23/20, 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). In addition, the Condition of Participation: Client Protection 42 CFR 483.420 found not met. HG500056C was substantiated with deficiencies issued at W122, W127, HG500059C was substantiated with no deficiencies issued. As a result of the complaint investigations deficiencies were also identified at W153 and W154.	W 000			
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed to protect a client who was being verbally abused by a staff member that was not immediately reported or protected for 1 of 1 clients (C20) reviewed for abuse.	W 122	see 127		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ 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	Continued From page 1 Findings include:	W 122		9/23/20
W 127	<p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to protect a client from abuse when a staff member was alleged to make verbal threats to hurt a client for 1 of 1 clients (C20) reviewed for abuse.</p> <p>Findings include:</p> <p>C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980. The EDF further indicated he had profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal.</p> <p>C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP</p>	W 127	<p>All investigations will be reviewed for the past 90 days to assure all clients have been protected from abuse.</p> <p>All QDDP's will be trained by the facility administrator on policy of suspending staff immediately when a maltreatment report has been made.</p> <p>All investigations are reviewed by the executive director and facility administrator within 3 days.</p>	9/23/20

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W 127	<p>Continued From page 2</p> <p>indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff.</p> <p>A Common Entry Report (CEP) dated 7/13/20, 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.</p> <p>A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore, the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and staff who are employees could not confirm any threats to C20. The report did not indicate what QDDP-B's conclusion was but the report was closed and signed by the administrator on 7/17/20.</p>	W 127			

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W 127	<p>Continued From page 3</p> <p>During interview on 7/21/20, at 9:30 a.m. with QDDP-R who stated she was informed of the allegation and called DSS-J to confirm if the allegation was true, adding DSS-J confirmed she had witnessed the verbal abuse and that DSS-J had not reported the allegation as required because she did not think DSS-X would actually hurt C20. C20 was unable to provide a specific date. QDDP-R stated she then notified QDDP-B of the incident who notified the administrator.</p> <p>During interview on 7/21/20, at 1:00 p.m. QDDP-B stated following his investigation, he felt the report was inconclusive because he did not have any problems with DSS-X and she had no disciplinary actions in her employment file when he looked today. He further stated he made multiple attempts to reach DSS-J and she did not return his calls, even though QDDP-R told her I would be calling. DSS-X also denied the allegations. He summarized by stating, since he did hear back from DSS-J and had no concerns, he felt the investigation was inconclusive.</p> <p>An addition, the GER Resolution dated 7/16/20, at 1:29 p.m. last updated by the director of oak street services (DOCS), indicated QDDP-B had several interviews dated 7/14/20 to 7/15/20 (no times documented) with staff, which concluded the following:</p> <ul style="list-style-type: none"> -Interview with DSS-X stated she has never threatened or told C20 she would harm him. -Interview with HHD-P stated DSS-X has a loud and demanding voice. -Interview with DSS-Y stated she had heard DSS-X use some name calling such as "brat" and some rough handling such as turning C20 away 	W 127	<p>All investigations will be reviewed for the past 90 doays. to assure completion</p> <p>The Facility administrator will complete investigations and interviews for the next 3 incidents to provied an example of how thorough complete investigation should be done.</p> <p>Training will be done with the QDDPs to show how to do a through investigation by the facility administrator. Each QDDP will be required to complete a fake investigation to show competency. We will be changing a procedure so the on call duties will be rotated so not just one person will soley be responsible for the investigations.</p> <p>Checking the employee file will be added to the investigation checklist.</p> <p>QDDPs will be retrained on the policy of suspending staff immediatly when there is an allegation of abuse or neglect. Competency will be determined via fake investigation role play.</p> <p>all investigations will be signed off by the facility administrator and executive diretor prior to event being closed.</p> <p>all completed by 9/23/20</p>	

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W 127	<p>Continued From page 4</p> <p>from door. But did not think DSS-X was abusive but could be gentler when turning him.</p> <p>-Interview with HHD-Q (former HHD) at North Oak who stated when DSS-X was impatient or frustrated with C20 she would offer to give her a break, she had counseled DSS-X about yelling at C20 in the past. She further indicated she would not schedule DSS-X for multiple days in a row to prevent burn-out because C20 can be challenging/exhausting.</p> <p>A facility e-mail sent from QDDP-B to DSS-X, QDDP-R and director of oak creek services indicated, "An allegation was made that you verbally threatened a client. The internal review of this allegation is inconclusive and allegation was not sustain/proven. You are able to report to work as scheduled on Monday 7/20/20. I want to meet with you Monday morning to discuss recommendations I have made as a result of the internal review."</p> <p>During observation 7/22/20, at 10:00 a.m. C20 was walking around in North Oak house. DSS-X was following him around going from room to room with him.</p> <p>During interview 7/22/20, at 10:15 a.m. the facility administrator stated DSS-J had received training in reporting and should have immediately reported this incident to us (DSS-J no longer worked at the facility). In addition, after reviewing internal investigation notes, she stated while interviewing, QDDP-B should have asked staff more questions when they stated DSS-X had yelled, named called or was being rough to find out more information. Further more, she stated QDDP-B had received training in the past about keeping a open mind in his decisions while doing</p>	W 127			

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W 127	<p>Continued From page 5</p> <p>his investigation and even though QDDP-R was the only one who received the interview from DSS-J about the allegation that should be enough. The administrator stated she will be following up with QDDP-B.</p> <p>Review of DSS-X employee file indicated the following:</p> <ul style="list-style-type: none"> - Employee Disciplinary Report (EDR) dated 5/17/12, indicated DSS-X had improper conduct and violation of policy and procedures. The report indicated it was written warning. The report further indicated DSS-X was making abusive, hostile comments and directives to other staff and students (Laura Baker school with clients that attended). -EDR dated 7/20/20, indicated incident 7/13/20, inappropriate interactions with clients. "During an internal review of an allegation, several persons indicated [DSS-X] may be exhausted and/or frustrated with client behavior and responded by yelling or using language that is contrary to treating clients with respect." The EDR indicated it was a written warning and consequence would be discipline up to and including termination signed by QDDP-B and DSS-X on 7/21/20. <p>QDDP-B's interval investigation was determined to be inconclusive despite having interviews from several interviews from staff stating she was loud, could be rough and was name calling, Furthermore, QDDP-B failed to asked additional questions of the staff when information was provided regarding potential rough handling and verbal abuse of clients by DSS-X. In addition, DSS-X was allowed to return to work and work directly with C20 on 7/21/20 without</p>	W 127			

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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 interactions with C2. The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 5/7/2020, 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 127			
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	W 153	see above		

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W 153	<p>Continued From page 7 officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately contact the administrator and state agency for 1 of 1 clients (C20) alleged to have been verbally abused.</p> <p>Findings include:</p> <p>C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980 with a diagnosis of profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal.</p> <p>C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff.</p> <p>A Common Entry Report (CEP) dated 7/13/20, 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</p>	W 153	<p>All investigations for the past 90 days will be reviewed to ensure appropriate documentation and immediately reported to state agency.</p> <p>QDDP's will be trained by the facility administrator on the facilities policy of reporting to MAARC immediatly when a maltreatment alligation is reported.</p> <p>All investigations are reviewed by the executive director and facility administrator within 3 days.</p>	9/23/20
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W 153	<p>Continued From page 8</p> <p>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.</p> <p>A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and no staff could confirm any threats to C20. Lastly this report indicted it was closed by the facility administrator on 7/17/20. The report did not indicate what QDDP-B's conclusion was but was signed by the administrator.</p> <p>During interview 7/21/20 at 9:30 a.m. with QDDP-R who stated she was informed of the all allegation and called DSS-J to see it was true and she said yes and stated she did not report the incident to the state or the facility administrator. QDDP-R stated DSS-J was unsure the exact date but QDDP-R knew she started after COVID so it was sometime after March 2020 and she only worked here just a few months. QDDP-R then notified QDDP-B of the incident who notified the administrator.</p>	W 153		

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W 153	Continued From page 9	W 153			
W 154	<p>STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate allegations of abuse for 1 of 1 client (C20) reviewed for staff to client abuse.</p> <p>Findings include:</p> <p>C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980 with a diagnosis of profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal.</p> <p>C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting</p>	W 154	<p>All reports will be reviewed for the past 90 days to assure thorough investigation has been completed</p> <p>QDDP's will be trained by the facility administrator on performing thorough investigations, QDDP's will perform a "fake" investigation to determine competency.</p> <p>All investigations are reviewed by the executive director and facility administrator within 3 days.</p>	9/23/20	

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W 154	<p>Continued From page 10</p> <p>procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff.</p> <p>A Common Entry Report (CEP) dated 7/13/20, 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.</p> <p>A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and staff who are employees could not confirm any threats to C20. Lastly this report indicted it was closed by the facility administrator on 7/17/20. The report did not</p>	W 154	see above		

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W 154	<p>Continued From page 11</p> <p>indicate what QDDP-B's conclusion was but the report was signed by the administrator.</p> <p>During interview 7/21/20 at 1:00 p.m. QDDP-B stated he felt the report was inconclusive because he did not have any problems with DSS-X and had no disciplinary actions in her employee file when he looked today. He further stated he made multiple attempts to reach DSS-J and she did not return his calls even though QDDP-R told her he would be calling. DSS-X also denied the allegations. He then stated since he did hear back from DSS-J and had no concerns he felt the investigation was inconclusive. Furthermore QDDP-B stated he did not interview the other clients in the home and had no explanation as to why he did not include that as part of his process.</p> <p>An addition, the GER Resolution dated 7/16/20, at 1:29 p.m. last updated by the director of oak street services, indicated QDDP-B had several interviews dated 7/14/20 to 7/15/20 with no times, with staff which concluded the following:</p> <ul style="list-style-type: none"> -Interview with HHD-P stated DSS-X has a loud and demanding voice. -Interview with DSS-Y stated she has heard DSS-X use some name calling such as "brat" and some rough handling such as turning C20 away from door. But did not this DSS-X was abusive but could be gentler when turning him. -Interview with DSS-X stated she has never threatened or told C20 she would harm him. -Interview with HHD-Q (former HHD)at North Oak who stated when DSS-X was impatient or frustrated with C20 she would offer to give her a break, she had counseled DSS-X about yelling at C20 in the past. She further indicated she would 	W 154		

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W 154	<p>Continued From page 12 not schedule DSS-X for multiple days in a row to prevent burn-out because C20 can be challenging/exhausting.</p> <p>Despite having several interviews from staff stating DSS-X was loud, could be rough with clients, and was observed calling clients names such as "brat", as well as gaining a history of previous concerns from her previous house supervisor of her direct behavior towards C20, QDDP-B's determination was inconclusive to abuse due to being unable to contact DSS-J himself (even though QDDP-R had already interviewed and received her report of the verbal abuse and physical threat made by DSS-X) and because there was not any history of concerns recorded in DSS-X's employee file. Further more QDDP-B failed to complete a thorough investigation when he did not inquire further regarding aggressive behavior reported during interviews gathered during the investigation and when QDDP-B failed to interview clients as part of the internal investigation.</p> <p>A facility policy revised 5/7/20, indicated 5. After reporting the incident of alleged abuse/neglect to the MAARC [Minnesota Adult Abuse Reporting Center] the programs mandated reporter will begin the internal investigation. The program reporter is responsible for using the checklists included in this policy for conducting a fair and impartial investigation. The internal review will also include an evaluation of whether related policies and procedures were followed and whether or not they were adequate, if there is a 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."</p>	W 154			

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