

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email October 21, 2020

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

RE: Event ID: 5CQP11

Project Number: HG500061C,HG500062C,HG500063C,HG500064C,HG500065C

Dear Administrator:

On 9/30/20 to 10/2/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.

HG500061C, HG500062C, HG500063C, HG500064C, and HG500065C were found to be substantiated, with no deficiencies cited.

However, as a result of the investigation a deficiency was identified.

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

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

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

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

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

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

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

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: 10/21/2020 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G500	B. WING			10/0)2/2020
	PROVIDER OR SUPPLIER	0001471011			TREET ADDRESS, CITY, STATE, ZIP CODE 11 OAK STREET	10/0	7212020
LAURA E	BAKER SERVICES AS	SOCIATION		N	ORTHFIELD, MN 55057		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	-S	W C	00			
	was completed at y complaint investigate compliance with 42	/20, an abbreviated survey our facility to conduct a tion. Your facility was not in CFR Part 483, subpart I, termediate Care Facilities for ellectual Disabilities.			POC 11/21/20 received 11/15/20 accepted 11/15/20		
	HG500064C, and H	00062C, HG500063C, IG500065C were found to be no deficiencies cited.					
W 153	However, as a resu deficiency was iden STAFF TREATMEN CFR(s): 483.420(d)	IT OF CLIENTS	W 1	53	All incidents for clients C5, C6, C7, C8, C9 v reviewed by program mandated reporter to a timely reporting was done.		11/21/20
	The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported				All incidents for all clients will be reviewed by mandated reporter to assure timely reporting	y progran g.	ⁿ 11/21/20
		administrator or to other nce with State law through ures.			Training for the program mandated reporte be conducted on reporting timely and assurif the incident was not reported within 2 hot corrective action and/or training is complete staff. Training to be conducted by facility administrator.	urs	11/21/20
	Based on interview facility failed to ensure ported immediate administrator and si	s not met as evidenced by: y and document review, the ure allegations of abuse were ly within 2 hours to the tate agency for 4 incidents ints (C5, C6, C7, C8, C9)			All mandated reports are reviewed by administrator and Executive director within	facility a 3 days.	11/21/20
	Findings include:						
		ata Form (EDF) generated C5's diagnoses included					
ADODATOD	/ DIDECTOR'S OF PROVID	ED/CLIDDI IED DEDDECENTATIVE'S CICI	LATUDE		TITI C		(Y6) DATE

Nicole Laudont Nicole Laudont

Director of Oak Street Services

3/30/21

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

	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24G500	B. WING	;			02/2020	
	PROVIDER OR SUPPLIER	SOCIATION		:	STREET ADDRESS, CITY, STATE, ZIP CODE 211 OAK STREET NORTHFIELD, MN 55057	101	0212020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)) BE	(X5) COMPLETION DATE	
W 153	severe intellectual of attention deficit hypconvulsions. C5's Individual Abudated 5/29/20, had potentially dangero being abused and hothers by swearing staff were to be prescribed by swearing staff were to be for avoiding target I with transitions by for	disabilities, autistic disorder, peractivity disorder, and see Prevention Plan (IAPP) an inability to identify us situations, was at risk for ad the potential to abuse, hitting or kicking others, and sent when not in his bedroom. For Plan (BSP) dated 4/24/20, at behaviors included physical others including hitting and verbal aggression. C5's BSP riggers for behaviors and tips behaviors, including assisting ollowing a set routine. d 10/1/20, indicated C6's generalized anxiety disorder, we disorder, and profound defined aggression and ng, pulling hair or clothes to ground, which could be clients in the household. C6's ceribed and indicated staff or esent at all times when she is	W 1	153				
	indicated C6's target and physical aggree	port Plan (BSP) dated 11/7/19, et behaviors included anxiety ssion, with triggers that ansition, being told "no", and						

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		24G500	B. WING		10	C //02/2020		
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W 153	were in place, incluinformed of inapproting to avoid target occurred, were also become more aggrouse to her or invainterventions include peers out of her resibetween C6 and petransitions. C7's EDF generated diagnoses included disability, anxiety dihyperactivity disord. C7's IAPP dated 2/for being abused an aggressive toward others, such as he would hug them ha individual into walls to have one-to-one hours with the excewith staff to interve activities, avoid commore people, and polysical aggression spitting at others in usually when not fe something, or does target behaviors individual aggre upset or randomly, one-to-one staff who concurred to the concept of the concept	do. Several interventions ding verbal redirection, opriateness of her behavior. In behaviors when each trigger of included. C6 was noted to ressive when people were too ding her space, and led staff to attempt to keep her each and place themselves ears, especially during stressful desorder, attention deficitiver, 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 red enough to slam the targeted for knock them down. C7 was staffing during all awake exption of 10 p.m. to 6:30 a.m., and and redirect to other and redirect to other and redirect to other and redirect to other and the such as hitting others or an attempt to communicate, welling well, does not want to do a not like something. C7's cluded panic attacks, spitting, assion which can happen when Staff were to provide inch was to avoid congested outs to hit others, suggest time	W 1	153				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		24G500	B. WING			1	02/2020
	PROVIDER OR SUPPLIER	SOCIATION		2	STREET ADDRESS, CITY, STATE, ZIP CODE 211 OAK STREET NORTHFIELD, MN 55057	100	02/2020
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)) BE	(X5) COMPLETION DATE
W 153	diagnoses included disability and interm C8's IAPP dated 7/2 for being abused ar physically and verbawas to have goals to inappropriate behave on every 15 minutes awake, and every 6 C8's BSP target be such as hitting, kick objects, or choking, reinforcement/rewal Interventions included appropriate activity aggression. C9's EDF generated diagnoses included intermittent explosivintellectual disability. C9's IAPP dated 7/2 for being abused, a appropriate bounda such as hugging and be supervised at he provide verbal redir on every 15 minutes awake, and every histaff were to interve aggression from an	d 10/2/20, indicated C8's a moderate intellectual nittent explosive disorder. 27/20, indicated C8 was at risk and had a history of being ally aggressive to others. C8 o work on decreasing viors and was to be checked is when alone in her room and 0 minutes when sleeping. Thaviors included aggression, sing, hair pulling, throwing and was on a rid system program. The differential edition for differential edition of the	W 1	153			

	AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		24G500	B. WING			1	C 02/2020		
	PROVIDER OR SUPPLIER	SOCIATION		2	TREET ADDRESS, CITY, STATE, ZIP CODE 11 OAK STREET IORTHFIELD, MN 55057	100			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
W 153	trigger of frustration staff were to redired A Common Entry P 8/23/20, at 10:40 p. 8/23/20, at 7:50 p.n and dug nails into C A CEP dated 9/18/2 9/17/20, at approximate when C6 exited her living room, turned and pulled on him. and C5 left the area incident was not repa.m. by the qualified professional (QDDF A General Event Redated 9/17/20, indicated 9/17/20, indicated 9/17/20, indicated Popper Service Several fin when he was grabbindicated QDDP-C the incident at the tidocumented on the reviewed and report on 9/18/20, at 12:54 A CEP report dated on 9/22/20, at approwhen C7 became uwas not fulfilled and the head. C9 became to a different sofa a	physical aggression, with a and not getting his way, and at C9 to another activity. oint (CEP) report dated m., indicated an incident on n. 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 P)-C. exports (GER) for an incident cated at 3:20 p.m. C5 was pulled off the sofa. C5 gernail scratches on his neck ed by his collar. The GER was present and responded to the of occurrence. QDDP-C GER, that the report was ted to the state agency (SA) p.m. 9/22/20, indicated an incident eximately 10:30 a.m. occurred pset with staff when a request a C7 slapped C9 on the top of the upset, and staff moved C7 and stayed with him. The CEP int was not reported until	W 1	153					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BU I LD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24G500	B. WING			1	0 2/2020
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 153	head at 10:30 a.m. was asked to wait f going outside without A CEP report dated on 10/1/20, at appropriate to 10/1/20, at appropriate to the SA of A GER dated 10/1/210/1/20, at 4:30 p.m. hall and slapped CS Staff intervened to GER indicated QDI reporter, was not not the same of the	20, indicated C7 hit C9 on the when C7 was upset when he or staff to assist him before ut shoes on. 10/1/20, indicated an incident eximately 4:50 p.m. occurred e9 on the back as he walked indicated the incident was not until 9:45 p.m. 20, indicated an incident on in. C7 was walking down the e9 on the back as he walked by. separate C7 and C9. The DP-C, the facility mandated obtified until 8:30 p.m. 1 a.m. qualified ibilities professional (QDDP)-C is received the report of gations, he reported it as soon 24 hours. QDDP-C stated he is to report within 2 hours. If usually report to him when the report later in their shift. It was present during C6's C5, and verified he did not in it within the guidelines. 1 a.m. QDDP-UU stated in andated reporter for the libe the one to make the SA, but QDDP-UU stated she	W 1	53			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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W 153	services (DOS)-TT potential abuse alle immediately from si as it safe to do so. allegation should the state agency. It trained staff to repountil the end of the state and the state agency are vised 5/7/2020, in volunteer who has readult or minor is be must report it immesafe and have apprential in the state of the s	6 a.m. director of facility at this location, verified gations should be reported taff to administrator, as soon DOS-TT stated the abuse en be reported immediately to DOS-TT stated they had rt right away and not to wait	W 1	53			



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed October 21, 2020

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

Re: Enclosed State Supervised Living Facility Licensing Orders - Project Number: HG500061C,

HG500062C, HG500063C, HG500064C, and HG500065C

Event ID: 5CQP11

Dear Administrator:

On 9/30/20 through 10/2/20, an abbreviated survey was completed to investigate complaints HG500061C, HG500062C, HG500063C, HG500064C, and HG500065C. The complaints were found to be substantiated. Your facility was NOT found in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

Page 2

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susie Haben. A written plan for correction of licensing orders is not required.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

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

Laura Baker Services Association

Page 3

PRINTED: 10/21/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		24G500	B. WING _			C 02/2020
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	OL/LULU
LAURA I	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 PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
W 000	INITIAL COMMEN	гѕ	W 00	00		
W 153	was completed at y complaint investigal compliance with 42 requirements for In Individuals with Intel HG500061C, HG50HG500064C, and H substantiated with Intel However, as a resudeficiency was idented STAFF TREATMENT CFR(s): 483.420(d). The facility must emistreatment, neglicinguries of unknown immediately to the officials in accordance stablished proced. This STANDARD is Based on interview facility failed to ensimported immediate administrator and sinvolving 5 of 5 clie reviewed for abuse. Findings include:	INT OF CLIENTS (2) Issure that all allegations of ect or abuse, as well as a source, are reported administrator or to other nice with State law through tures. Is not met as evidenced by: If and document review, the ture allegations of abuse were ely within 2 hours to the tate agency for 4 incidents ints (C5, C6, C7, C8, C9)	W 15	53		

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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		24G500	B. WING _		10	/ 02/2020	
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W 153	severe intellectual attention deficit hypconvulsions. C5's Individual Abudated 5/29/20, had potentially dangere being abused and others by swearing staff were to be preceded of the swear	disabilities, autistic disorder, peractivity disorder, and assert Prevention Plan (IAPP) an inability to identify an inability to identify as situations, was at risk for had the potential to abuse, hitting or kicking others, and esent when not in his bedroom. Port Plan (BSP) dated 4/24/20, et behaviors included physical others including hitting and verbal aggression. C5's BSP triggers for behaviors and tips behaviors, including assisting following a set routine. Ed 10/1/20, indicated C6's ageneralized anxiety disorder, we disorder, and profound y. I/29/19, indicated C6 was otentially dangerous situations, g abused and could display physical aggression and ing, pulling hair or clothes to a ground, which could be clients in the household. C6's scribed and indicated staff or esent at all times when she is	W 15	53			
	indicated C6's targ and physical aggre	port Plan (BSP) dated 11/7/19, et behaviors included anxiety ssion, with triggers that ransition, being told "no", and					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
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W 153	having too much to were in place, inclusion informed of inappr Tips to avoid targe occurred, were also become more agg close to her or invainterventions inclusion peers out of her resolution between C6 and putransitions. 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 wall to have one-to-one hours with the except with staff to intervent activities, avoid comore people, and C7's Behavior Supphysical aggression spitting at others in usually when not for something, or doe target behaviors in and physical aggresion and physical aggresion in a phy	age 2 o do. Several interventions uding verbal redirection, opriateness of her behavior. It behaviors when each trigger to included. C6 was noted to ressive when people were too ading her space, and ded staff to attempt to keep her each and place themselves eers, especially during stressful ded 10/2/20, indicated C7's deap a profound intellectual disorder, attention deficit der, and panic disorder. In 1/26/20, indicated C7 was at risk and had a history of being others by randomly hitting expassed them in hallways, or and enough to slam the targeted as or knock them down. C7 was extaffing during all awake eption of 10 p.m. to 6:30 a.m., ane and redirect to other ingested areas, or areas with provide verbal redirection. In 1/26/27/18, used on such as hitting others or an attempt to communicate, eeling well, does not want to do so not like something. C7's included panic attacks, spitting, ession which can happen when a Staff were to provide hich was to avoid congested apts to hit others, suggest time	W 15	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONST	COM	(X3) DATE SURVEY COMPLETED C		
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	PROVIDER OR SUPPLIER	SOCIATION		211 OAK	DDRESS, CITY, STATE, ZIP CODE STREET FIELD, MN 55057		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24G500	B. WING				C 02/2020	
	PROVIDER OR SUPPLIER	SOCIATION		211	REET ADDRESS, CITY, STATE, ZIP CODE I OAK STREET DRTHFIELD, MN 55057	10/	02/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)) BE	(X5) COMPLETION DATE	
W 153	behaviors included trigger of frustration staff were to redired A Common Entry P 8/23/20, at 10:40 p. 8/23/20, at 7:50 p.n and dug nails into C A CEP dated 9/18/2 9/17/20, at approximate when C6 exited her living room, turned and pulled on him. and C5 left the area incident was not repart a.m. by the qualifier professional (QDDI) A General Event Redated 9/17/20, indicated 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 pead. C9 becaute a different sofa at 12.50 and 13.50 and 14.50 and 15.50 and 15.	physical aggression, with a and not getting his way, and at C9 to another activity. oint (CEP) report dated m., indicated an incident on n. 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 P)-C. eports (GER) for an incident cated at 3:20 p.m. C5 was pulled off the sofa. C5 agernail scratches on his neck was present and responded to ime of occurrence. QDDP-C agernail scratches on his neck ted by his collar. The GER was present and responded to ime of occurrence. QDDP-C agernail scratches on his neck ted to the state agency (SA) 4 p.m. 19/22/20, indicated an incident oximately 10:30 a.m. occurred apset with staff when a request a C7 slapped C9 on the top of me upset, and staff moved C7 and stayed with him. The CEP nt was not reported until	W 1	53				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		24G500	B. WING_		10	/02/2020	
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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 153	A GER dated 9/22/head at 10:30 a.m. was asked to wait if going outside without A CEP report dated on 10/1/20, at appropriate when C7 slapped (by him. The CEP is reported to the SA A GER dated 10/1/10/1/20, at 4:30 p.r. hall and slapped Constaff intervened to GER indicated QD reporter, was not in the constant of the c	20, indicated C7 hit C9 on the when C7 was upset when he for staff to assist him before out shoes on. d 10/1/20, indicated an incident eximately 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 incident on incident 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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		24G500	B. WING			C (02/2020
NAME OF PROVIDER OR SUPPLIER LAURA BAKER SERVICES ASSOCIATION				STREET ADDRESS, CITY, STATE 211 OAK STREET NORTHFIELD, MN 55057		02/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
W 153	On 10/2/20, at 11:4 services (DOS)-TT potential abuse alle immediately from sas it safe to do so. allegation should the state agency. It trained staff to repountil the end of the The facility Policy & Prevention & Reporevised 5/7/2020, in volunteer who has adult or minor is be must report it immesafe and have apprential abuse 11:4	at this location, verified egations should be reported taff to administrator, as soon DOS-TT stated the abuse the be reported immediately to DOS-TT stated they had not right away and not to wait	W 1	53		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:		
		01163	B. WING		10/0	, 2/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAURA E	BAKER SERVICES AS	SSOCIATION 211 OAK NORTHFI	STREET ELD, MN 55	057		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
5 000	Initial Comments		5 000			
	144.56 and/or Minr 144.653, this correpursuant to a surve found that the deficiency of the Minnesota Deputermination of wear the Mindicated requires requirements of the number and MN Residuated below. We several items, failustems will be considered that the major of a fire violated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a sessing On 9/30/20 through	hether a violation has been compliance with all e rule provided at the tag ule number or MN Statute //hen a rule or statute contains re to comply with any of the dered lack of compliance. E upon re-inspection with any ule will result in the ne even if the item that was initial inspection was hearing on any assessments in non-compliance with these at a written request is made to thin 15 days of receipt of a lent for non-compliance.				
	HG500061C, HG50 HG500064C, and I were found to be s NOT found in comp	eted to investigate complaints 00062C, HG500063C, HG500065C. The complaints ubstantiated. Your facility was oliance with requirements of Chapter 4665 requirements for Facilities (SLF).				
5 815	MN Statute 626.55	7 Subd. 3. VA Timing of report.	5 815			

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

TITLE (X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			、
		01163	B. WING		1	, 2/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAURA	BAKER SERVICES AS	SSOCIATION 211 OAK				
	T	NORTHFI	ELD, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
5 815	Continued From pa	ige 1	5 815			
	(a) A mandated repbelieve that a vulne been maltreated, or vulnerable adult hat which is not reason immediately report common entry point vulnerable adult so admitted to a facility required to report sindividual that occurred unless: (1) the individual water another facility and reason to believe the maltreated in the post (2) the reporter known that the individual is defined in section of clause (4). (b) A person not reprovisions of this sereport as described (c) Nothing in this sknown or suspected reporter knows or heport has been made (d) Nothing in this sereporter from also reporter from also reporter from also reporter from also reported error was reported error was reported error was	porter who has reason to crable adult is being or has reason who has knowledge that a se sustained a physical injury hably explained shall the information to the st. If an individual is a lely because the individual is y, a mandated reporter is not suspected maltreatment of the red prior to admission, as admitted to the facility from the reporter has the vulnerable adult was revious facility; or lows or has reason to believe as a vulnerable adult as \$26.5572, subdivision 21, equired to report under the section may voluntarily				

Minnesota Department of Health

STATE FORM 5CQP11 If continuation sheet 2 of 9

Minnesota Department of Health

STATEMEN	AND DI AN OF CORRECTION INDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		01163	B. WING		10/0) 2/2020
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 10.0	
LAURA E	BAKER SERVICES AS	SOCIATION 211 OAK S	STREET ELD, MN 55	057		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
5 815	may provide to the to the lead agency event meets the cri subdivision 17, para lead agency shall c making an initial dissubdivision 9c. This MN Requirements: Based on interview facility failed to ens reported immediate administrator and s involving 5 of 5 clier reviewed for abuse	se (5), the reporter or facility common entry point or directly information explaining how the teria under section 626.5572, agraph (c), clause (5). The onsider this information when sposition of the report under ent is not met as evidenced and document review, the ure allegations of abuse were ely within 2 hours to the tate agency for 4 incidents ints (C5, C6, C7, C8, C9)	5 815			
	10/1/20, indicated of severe intellectual of attention deficit hypoconvulsions. C5's Individual Abundated 5/29/20, had potentially dangerous being abused and hothers by swearing, staff were to be preceded by the company of the com	ata Form (EDF) generated C5's diagnoses included disabilities, autistic disorder, eractivity disorder, and see Prevention Plan (IAPP) an inability to identify us situations, was at risk for ad the potential to abuse, hitting or kicking others, and sent when not in his bedroom. Fort Plan (BSP) dated 4/24/20, et behaviors included physical others including hitting and verbal aggression. C5's BSP riggers for behaviors and tips behaviors, including assisting				

Minnesota Department of Health

STATE FORM 5CQP11 If continuation sheet 3 of 9

Minnesota Department of Health

AND DIAN OF CORRECTION INDENTIFICATION NUMBER					B) DATE SURVEY COMPLETED	
		01163	B. WING		10/0) 2/2020
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	10/0	2/2020
I AURA I	BAKER SERVICES AS	SSOCIATION 211 OAK	STREET			
	Г	NORTHFI	ELD, MN 55			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
5 815	Continued From pa	ige 3	5 815			
	with transitions by f	ollowing a set routine.				
	diagnoses included intermittent explosi intellectual disability. C6's IAPP dated 11 unable to identify powas at risk for being behaviors such as yelling, kicking, hittipull a person to the disruptive to other obehaviors were designed.	/29/19, indicated C6 was otentially dangerous situations, g abused and could display physical aggression and ing, pulling hair or clothes to ground, which could be clients in the household. C6's scribed and indicated staff or esent at all times when she is				
	indicated C6's targer and physical aggre-included times of treating too much to were in place, incluinformed of inapprocession occurred, were also become more aggrescose to her or invainterventions include peers out of her reating to be the complete occurred. C7's EDF generated diagnoses included disability, anxiety disording the complete occurred of the complete occurred occurred.	cort Plan (BSP) dated 11/7/19, et behaviors included anxiety ssion, with triggers that ansition, being told "no", and do. Several interventions ding verbal redirection, opriateness of her behavior. It behaviors when each trigger of included. C6 was noted to essive when people were too ding her space, and led staff to attempt to keep her ach and place themselves eers, especially during stressful d 10/2/20, indicated C7's a profound intellectual isorder, attention deficit er, and panic disorder.				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		04400	B. WING		(
		01163	B. WING		10/0	2/2020
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
LAURA E	BAKER SERVICES AS	SSOCIATION 211 OAK S NORTHFI	ELD, MN 55	057		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
5 815	aggressive toward others, such as he would hug them ha individual into walls to have one-to-one hours with the exce with staff to interversion activities, avoid commore people, and proceed the common people, and procedure people, and procedur	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 agested areas, or areas with provide verbal redirection. Foort Plan dated 2/27/18, used a such as hitting others or an attempt to communicate, eling well, does not want to do not like something. C7's cluded panic attacks, spitting, assion which can happen when Staff were to provide lich was to avoid congested of the tothers, suggest time of 10/2/20, indicated C8's a moderate intellectual nittent explosive disorder. 27/20, indicated C8 was at risk and had a history of being ally aggressive to others. C8 to work on decreasing viors and was to be checked as when alone in her room and so minutes when sleeping.	5 815			

Minnesota Department of Health

STATE FORM 5099 5CQP11 If continuation sheet 5 of 9

Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION AND DED		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		01163	B. WING		10/0) 2/2020
	PROVIDER OR SUPPLIER	211 OAK 9		STATE, ZIP CODE	,	
LAURA E	BAKER SERVICES AS	SSOCIATION	ELD, MN 55	057		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
5 815	Continued From pa	ige 5	5 815			
	appropriate activity aggression.	without giving attention for				
	C9's EDF generated 10/2/20, indicated C9's diagnoses included a personality disorder, intermittent explosive disorder, and severe intellectual disability.					
	C9's IAPP dated 7/10/20, indicated C9 was at risk for being abused, and lacked understanding of appropriate boundaries and displayed behaviors such as hugging and kissing others. C9 was to be supervised at home and in the community and provide verbal redirection. C9 was to be checked on every 15 minutes when in his room and awake, and every hour when asleep. In addition, staff were to intervene when C9 was dealing with aggression from another person.					
	behaviors included trigger of frustration	10/20, indicated C9's target physical aggression, with a n and not getting his way, and ct C9 to another activity.				
	8/23/20, at 10:40 p	Point (CEP) report dated .m., indicated an incident on n. occurred when C8 grabbed C7's arm.				
	9/17/20, at approximate when C6 exited her living room, turned and pulled on him. and C5 left the area incident was not rea.m. by the qualifie professional (QDD)	20, indicated an incident on mately 3:20 p.m. occurred r 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 d developmental disability P)-C.				

Minnesota Department of Health

STATE FORM 5CQP11 If continuation sheet 6 of 9

Minnesota Department of Health

AND DI AN OF CORRECTION \ \ \ IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		01163	B. WING			C 02/2020
	NAME OF PROVIDER OR SUPPLIER LAURA BAKER SERVICES ASSOCIATION STREET AD 211 OAK NORTHFI			STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
5 815	dated 9/17/20, indic grabbed by C6 and received several fin when he was grabb indicated QDDP-C the incident at the t documented on the reviewed and report on 9/18/20, at 12:54 A CEP report dated on 9/22/20, at appropriate to a different sofa a indicated the incide 9/22/20, at 1:50 p.n. A GER dated 9/22/2 head at 10:30 a.m. was asked to wait f going outside without A CEP report dated on 10/1/20, at appropriate to the SA to A GER dated 10/1/2 to the SA to GER indicated QDI staff intervened to GER indicated in the case of the case	cated at 3:20 p.m. C5 was pulled off the sofa. C5 agernail scratches on his neck bed by his collar. The GER was present and responded to ime of occurrence. QDDP-C and GER, that the report was sted to the state agency (SA) 4 p.m. I 9/22/20, indicated an incident oximately 10:30 a.m. occurred upset with staff when a request at C7 slapped C9 on the top of me upset, and staff moved C7 and stayed with him. The CEP and was not reported until in. by the QDDP-C. 20, indicated C7 hit C9 on the when C7 was upset when he for staff to assist him before but shoes on. I 10/1/20, indicated an incident oximately 4:50 p.m. occurred c9 on the back as he walked andicated the incident was not until 9:45 p.m. 20, indicated an incident on in. C7 was walking down the end of the back as he walked by separate C7 and C9. The DP-C, the facility mandated otified until 8:30 p.m.				
	developmental disa	abilities professional (QDDP)-(s received the report of				

Minnesota Department of Health

STATE FORM 5699 5CQP11 If continuation sheet 7 of 9

Minnesota Department of Health

AND DIAN OF CORRECTION INDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04400	B. WING		100	
		01163			10/0	2/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAURA E	BAKER SERVICES AS	SSOCIATION 211 OAK S	ELD, MN 55	057		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
5 815	as possible, within did not know he wa QDDP-C stated stathey did the incident QDDP-C stated he aggression toward report it until the nethought it was report it was the nethought it was report it until the nethought it was report it immediately, on 10/2/20, at 11:4 services (DOS)-TT potential abuse alles immediately from sas it safe to do so allegation should the state agency. It trained staff to report it immediately from the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency and the safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency as a safe to do so allegation should the state agency. It is a safe to do so allegation should the state agency as a safe to do so allegation should the safe to do so allegat	egations, he reported it as soon 24 hours. QDDP-C stated he is to report within 2 hours. If usually report to him when it report later in their shift. Was present during C6's C5, and verified he did not ext day. QDDP-C stated he red within the guidelines. 1 a.m. QDDP-UU stated he had andated reporter for the did be the one to make the SA, but QDDP-UU stated she ports to the SA also. The report to the SA would be as soon as possible. 6 a.m. director of facility at this location, verified egations should be reported taff to administrator, as soon DOS-TT stated the abuse then be reported immediately to DOS-TT stated they had not right away and not to wait shift. 8 Procedures for the ring of Individual Maltreatment adicated any employee or reason to believe a vulnerable send or has been maltreated ediately and ensure clients are repriate supervision. In andicated the administrator	5 815			
	(21) days.	R CORRECTION: Twenty-one				

6899

Minnesota Department of Health STATE FORM

PRINTED: 10/21/2020

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ С B. WING _ 01163 10/02/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **211 OAK STREET** LAURA BAKER SERVICES ASSOCIATION NORTHFIELD, MN 55057 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

Minnesota Department of Health