DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

April 7, 2026

Administrator
Laura Baker Services Association

211 OAK STREET
NORTHFIELD, MN 55057

RE: Event ID: IC0U-H2

Dear Administrator:

On April 1, 2026 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G500	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	INITIAL COMMENTS On 4/01/26, an offsite revisit was conducted to follow up on deficiencies issued related to standard abbreviated survey exited on 2/10/26. Your facility was IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	W0000		

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 reverse for further 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.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

April 7, 2026

Administrator
LAURA BAKER SERVICES ASSOCIATION
211 OAK STREET
NORTHFIELD, MN 55057

Re: Enclosed Re-inspection Results - Event ID: IC0U-H2

Dear Administrator:

On April 1, 2026 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a re-inspection of your facility, to determine correction of orders found on the survey completed on February 10, 2026. At this time these correction orders were found corrected.

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

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **01163**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

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

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50000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 4/01/26, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 2/10/26, by the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	50000		

Office of Primary Care and Health Systems Management

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

March 5, 2026

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

RE: IC0U11

Dear Administrator:

On February 10, 2026, an extended survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. At the time of the survey, the survey team from the Minnesota Department of Health noted one or more deficiencies. At the conclusion of this survey, the surveyors advised you of the findings, including the fact that your facility does 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):

W122 42 CFR § 483.420 – Client Protections

W318 42 CFR § 483.460 42 – Health Care Services

Federal certification deficiencies are delineated on the electronically 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).

Failure to submit an acceptable written plan of correction for all Health Federal deficiencies within ten calendar days may result in additional remedies and/or decertification including a loss of federal reimbursement.

Your PoC must include:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 March 27, 2026, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 02/10/2026

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

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W 000	INITIAL COMMENTS On 2/04/26, 2/05/26 and 2/09/26 and 2/10/26 a standard 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. The following complaints were reviewed: HG5001480C (MN00115853) with deficiencies issued at W124. HG5003788C (MN00116052) The Condition of Participation: Client Protection 42 CFR 483.420 was found not to be met related to resident rights with deficiencies issued at W122, W149, W153 and W154. The Condition of The Condition of Participation: 42 CFR 483.460 42 was found not met related to Health Care Services with deficiencies issued at W318 and W344. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on observation, interview and document review, the Condition of Participation at 42 CFR	W 122		

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

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W 122	Continued From page 1 483.420 Client Protection, was not met. The facility failed to report and investigate a reported allegation of abuse for 1 of 1 client (C2) who had bruises on her back, buttocks and elbow which could have been suspicious to abuse. Findings include: See W149: The facility failed to implement abuse policies and procedures consistent with federal regulations by not investigating an injuries of unknown origin to the State Agency (SA) immediately for 1 of 1 client (C2) reviewed who had injuries of unknown origin on her back, buttocks and elbow which could have been suspicious to abuse. SeeW153: The facility failed to immediately report an injury of unknown origin to the State Agency (SA) for 1 of 1 client (C2) who had several injuries suspicious for alleged abuse. See W154: The facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 (C2) who had abrasions on her back, elbow and buttocks.	W 122		
W 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview, and document review, the facility failed to ensure clients rights were not	W 124		

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W 124	Continued From page 2	W 124		

restricted with use of a signed document restricting 1 of 1 client (C1) guardian (GA) the right to make and transport to medical appointments, choose providers and general care.

Findings include:

C1's Emergency Data Form (EDF) dated 4/17/24, indicate his date of birth was 9/25/1998. C1 had severe autism, severe intellectual disability, epilepsy, post Strep B with a ventricular peritoneal shunt (medical device used to relieve pressure on the brain caused by excess cerebrospinal fluid) with placement in 2023 due to obstructive hydrocephalus (build up of cerebral spinal fluid). The EDF indicated C1 was verbal, walked on his own and required 24 hour awake supervision. The EDF further indicated his GA was his emergency contact and medical guardian.

A Discharge Instructions from C1's primary hospital dated 10/21/25, indicated C1 was seen for shunt malfunction and was started on Olanzepine (Zprexia ZYDIS) (which is used for an atypical anti-psychotic used in adults and children to treat schizophrenia or bipolar disorder). The discharge instructions further indicated C1 was to follow up with his primary care provider (PCP) on 10/24/26, at 3:00 p.m.

During interview on 2/04/26 at 10:39 a.m., Ombudsman (O)-A (investigates and resolves complaints against government agencies or large organizations, acting as an intermediary to ensure fairness and advocate for people's rights, often through mediation, recommendations, or suggesting procedural changes, without taking

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W 124	Continued From page 3	W 124		

sides but rather for equitable processes) stated the facility wanted to control all aspects of C1's medical care. The facility registered nurse (RN)-A said she was responsible for all of C1's medical care and she filed a Adult Protection Report on GA when she removed C1 from the emergency department (D) in town and transported him to a hospital in the cities due to waiting over an hour in the ED because she felt he needed immediate care.

During interview on 2/04/26 at 8:01 p.m., GA stated on 10/24/25 C1 was sent to the local ED because he did not feel well, when she arrived he had been waiting there for a long time and after a total of one hour she stated she decided to take him to the hospital in the cities where he had his shunt surgery (preferred hospital). GA stated she was C1's medical decisions maker but when she left the ED she was forced to sign an against medical advice (AMA). GA stated the staff member from the facility (also at the hospital) even agreed he needed immediate attention. GA stated she knew he needed immediate attention because his eyes and pupils were so tiny and he could barley stand and knew something was very wrong and needed to see a neurosurgeon immediately. GA stated when he arrived to the hospital they immediately took him and he had shunt surgery due to his obstruction. The GA indicated because she made that decision, which she felt was in the best interest of C1, she was informed the facility would no longer allow her to take him to appointments and found out they had called adult protection on her. GA stated she has known C1 for 27 years, knows his symptoms of illness and can't understand why they would do this. In addition, GA stated the day he went into the hospital on 10/24/24, he was supposed to

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W 124	Continued From page 4 have a follow up appointment at his local primary clinic and was unaware of the reason for his appointment change, which delayed his follow until 10/28/25, C1 was not able to go to that appointment because he was in the hospital. During interview 2/05/25 at 2:53 p.m., hospital representative registered nurse (RN)-B indicated she was also informed by the hospital social worker C1's GA was forced to sign a document in which she could no longer make appointments or they would not take him back which was a rights violation. A facility document dated 11/05/25, labeled Expectations: indicated the following: 1) Following all healthcare policies and procedures. 2) Health team will make and take C1 to all scheduled appointments, to ensure paperwork is completed. 3) If there is an emergency, LBSA (Laura Baker Services Association) staff will address C1's medical needs first then contact his guardian. 4) If C1 is taken to the emergency department, we must follow all doctor's and medical personnel recommendations and C1 can not be signed out against medical advice (AMA). 5) Maintain communication with LBSA regarding C1's care and status. The document was signed by GA, RN-A and the director of oak street services (DOSS) on 11/05/2025. During phone interview on 2/05/26 at 8:55 a.m., C1's primary clinic representative (PCR) stated a nurse from the clinic (RN)-C reached out to the facility on 10/23/25 to follow up on C1's procedure	W 124		

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W 124	Continued From page 5 for his shunt and spoke to RN-A who indicated C's stitches were fine and he had no fever. The PCR then stated their notes indicated RN-C requested to complete an assessment for C1, with RN-A and she stated she was in a meeting and did not have time. PCR further indicated RN-A was the one who requested the appointment change from 10/24/25 to 10/28/25, per her (RN-A) and GA request. During interview on 2/05/26 at 4:05 p.m., RN-A stated on 10/23/25, she received a phone call from C1's primary's nurse (RN-C) and was told they wanted to change his scheduled appointment on 10/24/25, to 10/28/25 since it was scheduled with another physician with in the clinic and he prefers to see all of his own patients. When provided alternative information in conflict with RN-A response, she stated, Oh you mean the mother? Well she is wrong". RN-A went on to say, "Well it doesn't even matter, we have 5 days to have a follow up appointment with a physician after discharge from the hospital." Policies and Procedures Regarding Clients Rights revised 11/17/25, indicated it is the policy that each person receiving services and/or their legal representative their rights of each person as required by Minnesota and federal statues and regulations. These clients and protection-related rights are outlined in detail in the sections that follow. Each program will use a standard client, based on the Client Rights it is client right rights format as it is recommended and/or reported by the licensing entities.	W 124		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1)	W 149		

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W 149	Continued From page 6 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement abuse policies and procedures consistent with federal regulations by not investigating an injuries of unknown origin to the State Agency (SA) immediately for 1 of 1 client (C2) reviewed who had injuries of unknown origin on her back, buttocks and elbow which could have been suspicious to abuse. Findings include: C2's Emergency Data Form (EDF) dated 6/07/2024, indicated she had severe intellectual disability, autism and attention deficit disorder. The EDF further indicated C2 used picture boards to make common requests, is non-verbal used some signs staff must be familiar with, cries out for attention, walks on her own and required 24 hour supervision. C2's Individual Abuse Prevention Plan (IAPP) dated 1/09/26, indicated she would be likely to seek or cooperate in a abusive situation and all staff are trained to watch for signs and symptoms of abuse and vulnerable adult reporting. In addition, she had inability to identify potentially dangerous situations and verbally and aggressive persons. The IAAP indicated C2 bangs her head against hard surfaces (walls, floor, doors, windows, and radiators) and hits herself in the head when she is agitated and has flare-ups of Bursitis in her knee and ankle which is thought to be a result of her hitting her knees on walls and	W 149		

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W 149	Continued From page 7 doors when she is upset. Staff were directed to be attentive to her needs and to her modes of communication, padding is placed in her bedroom, and has knee pads to protect her knees which she has had limited success in wearing. A General Events Report (GER) entered on 1/22/26 at 8:42 a.m., by direct support staff (DSS)-A which was deleted on 1/22/26 at 3:10 p.m. by the assistant program director (APD), indicated a injury of unknown was discovered on 1/22/26 at 6:15 a.m. on her right buttock, right elbow and left shoulder and was listed as an abrasion. The summary indicated, "This morning when getting [C2] ready for her shower I noticed a large (approximately 5 in) red mark on her right buttock. I immediately had my coworker come in to observe and we did a body check and found another mark on her right elbow (aprox. 2 in) and also 2 on her left shoulder blade area. To us they appear as rug burn. We contacted evening staff, the household director (HHD)-A which is the person that showered her last night and the marks were not there. Overnight staff reported [C2] had ripped a couple papers off of the front door throughout the night but charted that she slept through the night. I called the mandated reporter line at 6:30 and :7:00 a.m. with no answer so I called the Director of Oaks Street Services (DOSS) but also no answer so I sent her a text at 7:15 am.". An After Visit Summary dated 1/23/26, indicated C2 was seen for red skin areas and the summary indicated the following instructions: right elbow area abrasion vs small area of eczema, right glueteal area likely abrasion. No evidence of infection (cellulitis), both areas are ok to observe	W 149		

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W 149	Continued From page 8 without treatment, could consider moisturizing cream or hydrocortisone cream to elbow. During observation and interview on 2/09/26 at 1:35 p.m., C2 was observed to be sitting in a chair in the main living area with a blanket over her head holding onto newspapers. HHD-A stated C2 likes to do that when she is in the house and stated she will also shred the paper up. HHD-A indicated C1 has had physical aggression towards others and herself and has had a history of elopement but none recent. The HHD-A stated she had new marks on her elbow, shoulder and buttocks that were reported to her but the next day when she worked she only saw the red mark on her buttocks. HHD-A stated DSS-A and DSS-B filed a GER and was not sure why it has been deleted from the computer system. During interview on 2/09/26 at 2:55 p.m., director of Oak Street Services (DOSS) stated she was informed of the injury of unknown origin on 1/22/26 in the morning but then was told the registered nurse (RN)-A looked at the areas and did not feel it was an injury of unknown origin. DOSS then stated she was informed C2 went to see the physician the following day and was told it was just eczema and there was no injury of unknown origin. The DOSS stated she was not aware the physician wrote on the referral the area on the buttocks was listed as abrasion vs eczema and with knowing that a GER should have been made and an investigation should have been immediately started for a injury of unknown origin. During interview on 2/10/26 at 2:06 p.m., RN-A stated she observed C2's skin on 1/22/26, and had her sent to the clinic on 1/23/26, since she	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 02/10/2026

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

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W 149	Continued From page 9 thought she might have cellulitis due to the warmth and redness on her skin. RN-A stated she was not aware a GER was completed as she does not have access to those reports. While the GER report was pulled up in Therap (electronic software used for documentation and record keeping) RN-A stated the assistant program director (APD) appeared to have deleted the GER. During interview on 2/10/26 at 2:30 p.m. the APD and DOSS, the APD stated she was told by the DOSS to delete the GER due to the RN-A telling her it was not a injury of unknown origin and it was cellulitis or dry skin. The DOSS stated a GER should have been completed in addition to a report to the state after C2 was seen by the physician the following day and diagnosed with right gluteal area likely abrasion. Facility's Abuse and Reporting policy revised 11/17/25,. indicated injuries of unknown origin will be investigated and immediately reported to the state agency.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an injury of unknown origin to the State Agency (SA) for 1 of 1 client (C2) who had serveral injuries suspicious	W 153		

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W 153	Continued From page 10 for alleged abuse. Findings include: C2's Emergency Data Form (EDF) dated 6/07/2024, indicated she had severe intellectual disability, autism and attention deficit disorder. The EDF further indicated C2 used picture boards to make common requests, is non-verbal used some signs staff must be familiar with, cries out for attention, walks on her own and required 24 hour supervision. A General Events Report (GER) entered on 1/22/26 at 8:42 a.m., by direct support staff (DSS)-A which was deleted on 1/22/26 at 3:10 p.m. by the assistant program director (APD), indicated a injury of unknown was discovered on 1/22/26 at 6:15 a.m. on her right buttock, right elbow and left shoulder and was listed as an abrasion. The summary indicated, "This morning when getting [C2] ready for her shower I noticed a large (approximately 5 in) red mark on her right buttock. I immediately had my coworker come in to observe and we did a body check and found another mark on her right elbow (aprox. 2 in) and also 2 on her left shoulder blade area. To us they appear as rug burn. We contacted evening staff, the household director (HHD)-A which is the person that showered her last night and the marks were not there. Overnight staff reported [C2] had ripped a couple papers off of the front door throughout the night but charted that she slept through the night. I called the mandated reporter line at 6:30 and :7:00 a.m. with no answer so I called the director of Oaks Street Services (DOSS) but also no answer so I sent her a text at 7:15 am.".	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 153	Continued From page 11 An After Visit Summary dated 1/23/26, indicated C2 was seen for red skin areas and the summary indicated the following instructions: right elbow area abrasion vs small area of eczema, right glueteal area likely abrasion. No evidence of infection (cellulitis), both areas are ok to observe without treatment, could consider moisturizing cream or hydrocortisone cream to elbow. During interview on 2/09/26 at 2:55 p.m., director of Oak Street Services (DOSS) stated she was informed of the injury of unknown origin on 1/22/26 in the morning but then was told the registered nurse (RN)-A looked at the areas and did not feel it was an injury of unknown origin. DOSS then stated she was informed C2 went to see the physician the following day and was told it was just eczema and there was no injury of unknown origin. The DOSS stated she was not aware the physician wrote on the referral the area on the buttocks was listed as abrasion vs eczema and with knowing that a GER should have been made and an investigation should have been immediately started for a injury of unknown origin. Facilities Abuse and Reporting policy revised 11/17/25, indicated any employee or volunteer who has reason to believe that a vulnerable adult or minor is being or has been maltreated, regardless of who is responsible for the mistreatment or who has knowledge that a vulnerable adult or minor has sustained a physical injury which is not reasonably explained is required by law to report immediately.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 154	Continued From page 12 violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 (C2) who had abrasions on her back, elbow and buttocks. Findings include: C2's Emergency Data Form (EDF) dated 6/07/2024, indicated she had severe intellectual disability, autism and attention deficit disorder. The EDF further indicated C2 used picture boards to make common requests, is non-verbal used some signs staff must be familiar with, cries out for attention, walks on her own and required 24 hour supervision. A General Events Report (GER) entered on 1/22/26 at 8:42 a.m., by direct support staff (DSS)-A which was deleted on 1/22/26 at 3:10 p.m. by the assistant program director (APD), indicated a injury of unknown was discovered on 1/22/26 at 6:15 a.m. on her right buttock, right elbow and left shoulder and was listed as an abrasion. The summary indicated, "This morning when getting [C2] ready for her shower I noticed a large (approximately 5 in) red mark on her right buttock. I immediately had my coworker come in to observe and we did a body check and found another mark on her right elbow (aprox. 2 in) and also 2 on her left shoulder blade area. To us they appear as rug burn. We contacted evening staff, the household director (HHD)-A which is the person that showered her last night and the marks were not there. Overnight staff reported [C2] had ripped a couple papers off of the front door throughout the night but charted that she slept through the night. I called the mandated	W 154		

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W 154	Continued From page 13 reporter line at 6:30 and :7:00 a.m. with no answer so I called the director of Oaks Street Services (DOSS) but also no answer so I sent her a text at 7:15 am.". An After Visit Summary dated 1/23/26, indicated C2 was seen for red skin areas and the summary indicated the following instructions: right elbow area abrasion vs small area of eczema, right glueteal area likely abrasion. No evidence of infection (cellulitis), both areas are ok to observe without treatment, could consider moisturizing cream or hydrocortisone cream to elbow. During interview on 2/09/26 at 2:55 p.m., director of Oak Street Services (DOSS) stated she was informed of the injury of unknown origin on 1/22/26 in the morning but then was told the registered nurse (RN)-A looked at the areas and did not feel it was an injury of unknown origin. DOSS then stated she was informed C2 went to see the physician the following day and was told it was just eczema and there was no injury of unknown origin. The DOSS stated she was not aware the physician wrote on the referral the area on the buttocks was listed as abrasion vs eczema and with knowing that a GER should have been made and an investigation should have been immediately started for a injury of unknown origin. During observation and interview on 2/09/26 at 1:35 p.m., C2 was observed to be sitting in a chair in the main living area with a blanket over her head holding onto newspapers. HHD-A stated C2 likes to do that when she is in the house and stated she will also shred the paper up. HHD-A indicated C1 has had physical aggression towards others and herself and has had a history of elopement but none recent. The	W 154		

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W 154	Continued From page 14 HHD-A stated she had new marks on her elbow, shoulder and buttocks that were reported to her but the next day when she worked she only saw the red mark on her buttocks. HHD-A stated DSS-A and DSS-B filed a GER and was not sure why it has been deleted from the computer system. During interview on 2/10/26 at 2:06 p.m., RN-A stated she observed C2's skin on 1/22/26, and had her sent to the clinic on 1/23/26, since she thought she might have cellulitis due to the warmth and redness on her skin. RN-A stated she was not aware a GER was completed as she does not have access to those reports. While the GER report was pulled up in Therap (electronic software used for documentation and record keeping) RN-A stated the assistant program director (APD) appeared to have deleted the GER. During interview on 2/10/26 at 2:30 p.m. the APD and DOSS, the APD stated she was told by the DOSS to delete the GER due to the RN-A telling her it was not a injury of unknown origin and it was cellulitis or dry skin. The DOSS stated a GER should have been completed in addition to a report to the state after C2 was seen by the physician the following day and diagnosed with right glutei area likely abrasion. Facilities Abuse and Reporting policy revised 11/17/25,. indicated any employee or volunteer who has reason to believe that a vulnerable adult or minor is being or has been maltreated, regardless of who is responsible for the mistreatment or who has knowledge that a vulnerable adult or minor has sustained a physical injury which is not reasonably explained	W 154		

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W 154	Continued From page 15 is required by law to report immediately. The policy further indicated ater a report is made the programs mandated reporter will begin the internal investigation using the checklists included for conducting a fair and impartial investigation.	W 154		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: The Condition of Participation: 42 CFR 483.460 42 Health Care Services was found when the facility failed to provide nursing services and/or adequate competent staff for C1 who was he was medically cleared to return home and remained at the hosptial for an extended 12 days. Findings include: See W344: The facility failed to provide sufficient licensed nursing staff and/or competent staff to allow 1 of 1 client (C1) to return from the hospital when medically cleared which resulted in an extended hospital stay of 12 days.	W 318		
W 344	NURSING STAFF CFR(s): 483.460(d)(2) The facility must employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to provide sufficient licensed nursing	W 344		

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W 344	Continued From page 16 staff and/or competent staff to allow 1 of 1 client (C1) to return from the hospital when medically cleared which resulted in an extended hospital stay of 12 days. Findings include: C1's Emergency Data Form (EDF) dated 4/17/24, indicate his date of birth was 9/25/1998. C1 had severe autism, severe intellectual disability, epilepsy, post Strep B with a ventricular peritoneal shunt (medical device used to relieve pressure on the brain caused by excess cerebrospinal fluid) with placement in 2023 due to obstructive hydrocephalus (build up of cerebral spinal fluid.) The EDF indicated C1 was verbal, walked on his own and required 24 hour awake supervision. The EDF further indicated his GA was his emergency contact and medical guardian. During interview on 2/04/26 at 8:01 p.m., GA stated on 10/24/25, C1 was sent to the local emergency department (ED) because he did not feel well, when she arrived he had been waiting there for a long time and after a total of one hour she stated she decided to take him to the hospital in the cities where he had his shunt surgery (preferred hospital). GA stated she was C1's medical decision maker but when she left the ED she was forced to sign an against medical advice form (AMA). GA stated the staff member from the facility (also at the hospital) even agreed he needed immediate attention. GA stated she knew he needed immediate attention because his eyes and pupils were so tiny and he could barley stand and knew something was very wrong and needed to see a neurosurgeon immediately. GA stated when he arrived to the hospital they immediately	W 344		

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W 344	Continued From page 17 took him and he had shunt surgery due to his obstruction. The GA indicated because she made that decision, which she felt was in the best interest of C1, she was informed the facility would no longer allow her to take him to appointments and found out they had called adult protection on her. GA stated she has known C1 for 27 years, knows his symptoms of illness and can't understand why they would do this. In addition, GA stated the day he went into the hospital on 10/24/25, he was supposed to have a follow up appointment at his local primary clinic and was unaware of the reason for his appointment change, which delayed his follow until 10/28/25. C1 was not able to go to that appointment because he was in the hospital. Lastly, GA stated she was also upset when C1 was left in the hospital unnecessarily until 12/16/25 when he was medically cleared to return on 12/04/25, and was able to ambulate independently. During interview 2/05/25 at 2:53 p.m., hospital representative registered nurse (RN)-B indicated C1's hospitalization occurred from 10/25/25 to 12/16/25. RN-B stated C1 was medically and physically ready to discharge from the hospital on 12/04/25, but the facility RN-A stated she was on vacation and no one in the facility would be able to accept C1's return which required an unavoidable hospital stay for 12 days. During phone interview on 2/05/26 at 8:55 a.m., C1's primary clinic representative (PCR) stated a nurse from the clinic (RN)-C reached out to the facility on 10/23/25 to follow up on C1's procedure for his shunt and spoke to RN-A who indicated C1's stitches were fine and he had no fever. The PCR then stated their notes indicated RN-C requested to complete an assessment for C1,	W 344		

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W 344	Continued From page 18 with RN-A and she stated she was in a meeting and did not have time. PCR further indicated RN-A was the one who requested the appointment change from 10/24/25 to 10/28/25, per her (RN-A) and GA request. During interview on 2/05/26 at 3:05 p.m. household director (HHD-A) stated when she went to the hospital the first week of December she walked with C1 without a belt and he seemed like he would be able to return back home. During interview on 2/05/26 at 4:14 p.m., facility RN-A stated she informed the hospital case manager a week prior she would be on vacation from 12/05/25 to 12/15/25, and if C1 was going to return from the hospital she would have to let her know the morning of 12/04/25, and she would be leaving by noon. if C1 was going to return it would have to before noon that day otherwise he would have to return after her vacation. Oak Street Admissions Policies and Procedures revised 11/17/2025, to retain placement, individuals admitted will need to continue to meet ICF-DD (Intermediate Care Facilities for Developmentally Disabled) guidelines for active treatment, ambulation, and medical standards. The policy indicated they must be able to ambulate independently, must not need more licensed nursing care than can be provided in a regular shift, refusal to admit a person to LBSA will be based on the evaluation of the person's assessed needs and the lack of capacity to meet the needs of the person. Documentation of the basis of refusal will be provided to the person, the person's legal representative and case manager upon request.	W 344		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

March 5, 2026

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

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: IC0U11

Dear Administrator:

The above facility was surveyed on February 4, 2026 through February 10, 2026 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

The first page of the state orders should be signed and submitted to:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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 the supervisor listed above. A written plan for correction of licensing orders is not required.

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

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01163	A. BUILDING: _____ B. WING _____	C 02/10/2026

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LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 2/4/26, 2/05/26 and 2/09/26 and 2/10/26 a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaints were reviewed: HG5001480C (MN00115853) and HG5003788C (MN00116052) with no licensing order issued.	5 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01163	A. BUILDING: _____ B. WING _____	C 02/10/2026

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

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5 000	Continued From page 1 As a result of the survey investigation, a licensing order was issued at 0815. When corrections are completed, please sign and date, make a copy of these orders and electronically return to: susie.haben@state.mn.us	5 000		
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	5 815		

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5 815	Continued From page 2 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an injury of unknown origin to the State Agency (SA) for 1 of 1 client (C2) who had serveral injuries suspicious for alleged abuse. Findings include: C2's Emergency Data Form (EDF) dated 6/07/2024, indicated she had severe intellectual disability, autism and attention deficit disorder. The EDF further indicated C2 used picture boards to make common requests, is non-verbal used some signs staff must be familiar with, cries out for attention, walks on her own and required 24 hour supervision.	5 815		

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5 815	Continued From page 3 A General Events Report (GER) entered on 1/22/26 at 8:42 a.m., by direct support staff (DSS)-A which was deleted on 1/22/26 at 3:10 p.m. by the assistant program director (APD), indicated a injury of unknown was discovered on 1/22/26 at 6:15 a.m. on her right buttock, right elbow and left shoulder and was listed as an abrasion. The summary indicated, "This morning when getting [C2] ready for her shower I noticed a large (approximately 5 in) red mark on her right buttock. I immediately had my coworker come in to observe and we did a body check and found another mark on her right elbow (aprox. 2 in) and also 2 on her left shoulder blade area. To us they appear as rug burn. We contacted evening staff, the household director (HHD)-A which is the person that showered her last night and the marks were not there. Overnight staff reported [C2] had ripped a couple papers off of the front door throughout the night but charted that she slept through the night. I called the mandated reporter line at 6:30 and :7:00 a.m. with no answer so I called the director of Oaks Street Services (DOSS) but also no answer so I sent her a text at 7:15 am.". An After Visit Summary dated 1/23/26, indicated C2 was seen for red skin areas and the summary indicated the following instructions: right elbow area abrasion vs small area of eczema, right glueteal area likely abrasion. No evidence of infection (cellulitis), both areas are ok to observe without treatment, could consider moisturizing cream or hydrocortisone cream to elbow. During interview on 2/09/26 at 2:55 p.m., director of Oak Street Services (DOSS) stated she was informed of the injury of unknown origin on 1/22/26 in the morning but then was told the registered nurse (RN)-A looked at the areas and	5 815		

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5 815	Continued From page 4 did not feel it was an injury of unknown origin. DOSS then stated she was informed C2 went to see the physician the following day and was told it was just eczema and there was no injury of unknown origin. The DOSS stated she was not aware the physician wrote on the referral the area on the buttocks was listed as abrasion vs eczema and with knowing that a GER should have been made and an investigation should have been immediately started for a injury of unknown origin. Facilities Abuse and Reporting policy revised 11/17/25, indicated any employee or volunteer who has reason to believe that a vulnerable adult or minor is being or has been maltreated, regardless of who is responsible for the mistreatment or who has knowledge that a vulnerable adult or minor has sustained a physical injury which is not reasonably explained is required by law to report immediately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 815		

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W 000	INITIAL COMMENTS On 2/04/26, 2/05/26 and 2/09/26 and 2/10/26 a standard 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. The following complaints were reviewed: HG5001480C (MN00115853) with deficiencies issued at W124. HG5003788C (MN00116052) The Condition of Participation: Client Protection 42 CFR 483.420 was found not to be met related to resident rights with deficiencies issued at W122, W149, W153 and W154. The Condition of The Condition of Participation: 42 CFR 483.460 42 was found not met related to Health Care Services with deficiencies issued at W318 and W344. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	W 000	intentionally left blank received 3/20/26 POC 3/27/26 approved 3/24/26 Susie Haben	3/27/26
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on observation, interview and document review, the Condition of Participation at 42 CFR	W 122	See 124, W149, W153, W154	

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

TITLE
Director

(X6) DATE
3/11/26

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 1 483.420 Client Protection, was not met. The facility failed to report and investigate a reported allegation of abuse for 1 of 1 client (C2) who had bruises on her back, buttocks and elbow which could have been suspicious to abuse. Findings include: See W149: The facility failed to implement abuse policies and procedures consistent with federal regulations by not investigating an injuries of unknown origin to the State Agency (SA) immediately for 1 of 1 client (C2) reviewed who had injuries of unknown origin on her back, buttocks and elbow which could have been suspicious to abuse. SeeW153: The facility failed to immediately report an injury of unknown origin to the State Agency (SA) for 1 of 1 client (C2) who had several injuries suspicious for alleged abuse. See W154: The facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 (C2) who had abrasions on her back, elbow and buttocks.	W 122		
W 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview, and document review, the facility failed to ensure clients rights were not	W122 cont. W 124	See 124, W149, W153, W154	

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W 124	Continued From page 2 restricted with use of a signed document restricting 1 of 1 client (C1) guardian (GA) the right to make and transport to medical appointments, choose providers and general care. Findings include: C1's Emergency Data Form (EDF) dated 4/17/24, indicate his date of birth was 9/25/1998. C1 had severe autism, severe intellectual disability, epilepsy, post Strep B with a ventricular peritoneal shunt (medical device used to relieve pressure on the brain caused by excess cerebrospinal fluid) with placement in 2023 due to obstructive hydrocephalus (build up of cerebral spinal fluid). The EDF indicated C1 was verbal, walked on his own and required 24 hour awake supervision. The EDF further indicated his GA was his emergency contact and medical guardian. A Discharge Instructions from C1's primary hospital dated 10/21/25, indicated C1 was seen for shunt malfunction and was started on Olanzepine (Zprexia ZYDIS) (which is used for an atypical anti-psychotic used in adults and children to treat schizophrenia or bipolar disorder). The discharge instructions further indicated C1 was to follow up with his primary care provider (PCP) on 10/24/26, at 3:00 p.m. During interview on 2/04/26 at 10:39 a.m., Ombudsman (O)-A (investigates and resolves complaints against government agencies or large organizations, acting as an intermediary to ensure fairness and advocate for people's rights, often through mediation, recommendations, or suggesting procedural changes, without taking	W 124	Administrative staff reviewed care coordination practicies for all individuals receiving services to ensure guardians remain informaed and involved in medical deicsion making. The facility administration clarified procedures with facility nurse on communication with guardians when coordinating hospital care and medical follow up. Director will review and train on role boundary and expectations with the facility nurse to ensure collaboration in medical decision making, guardian rights and communication expectations Policies related to client rights and guardian communication will be reviewed by facility adminsitration and provide training on any updates to the necessary staff Director will review documenation of guardian communication during quarterly record reeviews Director Of oask street is responsible for completion the expectations agreement was removed and that the facility will no longer use such agreements.	3/27/26

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W 124	Continued From page 3 sides but rather for equitable processes) stated the facility wanted to control all aspects of C1's medical care. The facility registered nurse (RN)-A said she was responsible for all of C1's medical care and she filed a Adult Protection Report on GA when she removed C1 from the emergency department (D) in town and transported him to a hospital in the cities due to waiting over an hour in the ED because she felt he needed immediate care. During interview on 2/04/26 at 8:01 p.m., GA stated on 10/24/25 C1 was sent to the local ED because he did not feel well, when she arrived he had been waiting there for a long time and after a total of one hour she stated she decided to take him to the hospital in the cities where he had his shunt surgery (preferred hospital). GA stated she was C1's medical decisions maker but when she left the ED she was forced to sign an against medical advice (AMA). GA stated the staff member from the facility (also at the hospital) even agreed he needed immediate attention. GA stated she knew he needed immediate attention because his eyes and pupils were so tiny and he could barley stand and knew something was very wrong and needed to see a neurosurgeon immediately. GA stated when he arrived to the hospital they immediately took him and he had shunt surgery due to his obstruction. The GA indicated because she made that decision, which she felt was in the best interest of C1, she was informed the facility would no longer allow her to take him to appointments and found out they had called adult protection on her. GA stated she has known C1 for 27 years, knows his symptoms of illness and can't understand why they would do this. In addition, GA stated the day he went into the hospital on 10/24/24, he was supposed to	W 124	see above	

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W 124	Continued From page 4 have a follow up appointment at his local primary clinic and was unaware of the reason for his appointment change, which delayed his follow until 10/28/25, C1 was not able to go to that appointment because he was in the hospital. During interview 2/05/25 at 2:53 p.m., hospital representative registered nurse (RN)-B indicated she was also informed by the hospital social worker C1's GA was forced to sign a document in which she could no longer make appointments or they would not take him back which was a rights violation. A facility document dated 11/05/25, labeled Expectations: indicated the following: 1) Following all healthcare policies and procedures. 2) Health team will make and take C1 to all scheduled appointments, to ensure paperwork is completed. 3) If there is an emergency, LBSA (Laura Baker Services Association) staff will address C1's medical needs first then contact his guardian. 4) If C1 is taken to the emergency department, we must follow all doctor's and medical personnel recommendations and C1 can not be signed out against medical advice (AMA). 5) Maintain communication with LBSA regarding C1's care and status. The document was signed by GA, RN-A and the director of oak street services (DOSS) on 11/05/2025. During phone interview on 2/05/26 at 8:55 a.m., C1's primary clinic representative (PCR) stated a nurse from the clinic (RN)-C reached out to the facility on 10/23/25 to follow up on C1's procedure	W 124	see above	

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W 124	Continued From page 5 for his shunt and spoke to RN-A who indicated C's stitches were fine and he had no fever. The PCR then stated their notes indicated RN-C requested to complete an assessment for C1, with RN-A and she stated she was in a meeting and did not have time. PCR further indicated RN-A was the one who requested the appointment change from 10/24/25 to 10/28/25, per her (RN-A) and GA request. During interview on 2/05/26 at 4:05 p.m., RN-A stated on 10/23/25, she received a phone call from C1's primary's nurse (RN-C) and was told they wanted to change his scheduled appointment on 10/24/25, to 10/28/25 since it was scheduled with another physician with in the clinic and he prefers to see all of his own patients. When provided alternative information in conflict with RN-A response, she stated, Oh you mean the mother? Well she is wrong". RN-A went on to say, "Well it doesn't even matter, we have 5 days to have a follow up appointment with a physician after discharge from the hospital." Policies and Procedures Regarding Clients Rights revised 11/17/25, indicated it is the policy that each person receiving services and/or their legal representative their rights of each person as required by Minnesota and federal statues and regulations. These clients and protection-related rights are outlined in detail in the sections that follow. Each program will use a standard client, based on the Client Rights it is client right rights format as it is recommended and/or reported by the licensing entities.	W 124	see above	
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1)	W 149		

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W 149	Continued From page 6 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement abuse policies and procedures consistent with federal regulations by not investigating an injuries of unknown origin to the State Agency (SA) immediately for 1 of 1 client (C2) reviewed who had injuries of unknown origin on her back, buttocks and elbow which could have been suspicious to abuse. Findings include: C2's Emergency Data Form (EDF) dated 6/07/2024, indicated she had severe intellectual disability, autism and attention deficit disorder. The EDF further indicated C2 used picture boards to make common requests, is non-verbal used some signs staff must be familiar with, cries out for attention, walks on her own and required 24 hour supervision. C2's Individual Abuse Prevention Plan (IAPP) dated 1/09/26, indicated she would be likely to seek or cooperate in a abusive situation and all staff are trained to watch for signs and symptoms of abuse and vulnerable adult reporting. In addition, she had inability to identify potentially dangerous situations and verbally and aggressive persons. The IAAP indicated C2 bangs her head against hard surfaces (walls, floor, doors, windows, and radiators) and hits herself in the head when she is agitated and has flare-ups of Bursitis in her knee and ankle which is thought to be a result of her hitting her knees on walls and	W 149	all abuse and neglect policies will be implemented per regulation and policy all employees will be provided with training on policy The Director of Oak Street Services is responsible for ensuring training is complete and implemented All internal investigations are reviewed by the executive director within 5 days to ensure compliance with regulations and policies.	3/27/26

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W 149	Continued From page 7 doors when she is upset. Staff were directed to be attentive to her needs and to her modes of communication, padding is placed in her bedroom, and has knee pads to protect her knees which she has had limited success in wearing. A General Events Report (GER) entered on 1/22/26 at 8:42 a.m., by direct support staff (DSS)-A which was deleted on 1/22/26 at 3:10 p.m. by the assistant program director (APD), indicated a injury of unknown was discovered on 1/22/26 at 6:15 a.m. on her right buttock, right elbow and left shoulder and was listed as an abrasion. The summary indicated, "This morning when getting [C2] ready for her shower I noticed a large (approximately 5 in) red mark on her right buttock. I immediately had my coworker come in to observe and we did a body check and found another mark on her right elbow (aprox. 2 in) and also 2 on her left shoulder blade area. To us they appear as rug burn. We contacted evening staff, the household director (HHD)-A which is the person that showered her last night and the marks were not there. Overnight staff reported [C2] had ripped a couple papers off of the front door throughout the night but charted that she slept through the night. I called the mandated reporter line at 6:30 and :7:00 a.m. with no answer so I called the Director of Oaks Street Services (DOSS) but also no answer so I sent her a text at 7:15 am.". An After Visit Summary dated 1/23/26, indicated C2 was seen for red skin areas and the summary indicated the following instructions: right elbow area abrasion vs small area of eczema, right glueteal area likely abrasion. No evidence of infection (cellulitis), both areas are ok to observe	W 149	see above	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 8 without treatment, could consider moisturizing cream or hydrocortisone cream to elbow. During observation and interview on 2/09/26 at 1:35 p.m., C2 was observed to be sitting in a chair in the main living area with a blanket over her head holding onto newspapers. HHD-A stated C2 likes to do that when she is in the house and stated she will also shred the paper up. HHD-A indicated C1 has had physical aggression towards others and herself and has had a history of elopement but none recent. The HHD-A stated she had new marks on her elbow, shoulder and buttocks that were reported to her but the next day when she worked she only saw the red mark on her buttocks. HHD-A stated DSS-A and DSS-B filed a GER and was not sure why it has been deleted from the computer system. During interview on 2/09/26 at 2:55 p.m., director of Oak Street Services (DOSS) stated she was informed of the injury of unknown origin on 1/22/26 in the morning but then was told the registered nurse (RN)-A looked at the areas and did not feel it was an injury of unknown origin. DOSS then stated she was informed C2 went to see the physician the following day and was told it was just eczema and there was no injury of unknown origin. The DOSS stated she was not aware the physician wrote on the referral the area on the buttocks was listed as abrasion vs eczema and with knowing that a GER should have been made and an investigation should have been immediately started for a injury of unknown origin. During interview on 2/10/26 at 2:06 p.m., RN-A stated she observed C2's skin on 1/22/26, and had her sent to the clinic on 1/23/26, since she	W 149	see above	

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W 149	Continued From page 9 thought she might have cellulitis due to the warmth and redness on her skin. RN-A stated she was not aware a GER was completed as she does not have access to those reports. While the GER report was pulled up in Therap (electronic software used for documentation and record keeping) RN-A stated the assistant program director (APD) appeared to have deleted the GER. During interview on 2/10/26 at 2:30 p.m. the APD and DOSS, the APD stated she was told by the DOSS to delete the GER due to the RN-A telling her it was not a injury of unknown origin and it was cellulitis or dry skin. The DOSS stated a GER should have been completed in addition to a report to the state after C2 was seen by the physician the following day and diagnosed with right gluteal area likely abrasion. Facility's Abuse and Reporting policy revised 11/17/25,. indicated injuries of unknown origin will be investigated and immediately reported to the state agency.	W 149	see above	
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an injury of unknown origin to the State Agency (SA) for 1 of 1 client (C2) who had serveral injuries suspicious	W 153		

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W 153	Continued From page 10 for alleged abuse. Findings include: C2's Emergency Data Form (EDF) dated 6/07/2024, indicated she had severe intellectual disability, autism and attention deficit disorder. The EDF further indicated C2 used picture boards to make common requests, is non-verbal used some signs staff must be familiar with, cries out for attention, walks on her own and required 24 hour supervision. A General Events Report (GER) entered on 1/22/26 at 8:42 a.m., by direct support staff (DSS)-A which was deleted on 1/22/26 at 3:10 p.m. by the assistant program director (APD), indicated a injury of unknown was discovered on 1/22/26 at 6:15 a.m. on her right buttock, right elbow and left shoulder and was listed as an abrasion. The summary indicated, "This morning when getting [C2] ready for her shower I noticed a large (approximately 5 in) red mark on her right buttock. I immediately had my coworker come in to observe and we did a body check and found another mark on her right elbow (aprox. 2 in) and also 2 on her left shoulder blade area. To us they appear as rug burn. We contacted evening staff, the household director (HHD)-A which is the person that showered her last night and the marks were not there. Overnight staff reported [C2] had ripped a couple papers off of the front door throughout the night but charted that she slept through the night. I called the mandated reporter line at 6:30 and :7:00 a.m. with no answer so I called the director of Oaks Street Services (DOSS) but also no answer so I sent her a text at 7:15 am.".	W 153	C2s injury was reported to MAARC All reports made to the program mandated reporter that meet the criteria for an unknown injury will be reported to MAARC per regulations/policy. Program Mandated Reporters will be trained on policies for reporting to the central agency (MAARC) by the Director of Oak Street Services within the required time frame. Program Mandated Reporters/Internal reporters will be trained on completing a complete investigation and completing the investigation checklist in policy when completing an investigation. All items are documented in internal investigation GER resolution on therap. Recommendations are assigned to specific individuals by the program mandated reporter and tracked within the GER resolution. The investigations are reviewed and closed by the executive director within 5 days of the initial report to ensure completion. Clients have body check programs within their daily tracking programs. Staff are prompted within the program to report any suspicious injuries to the program mandated reporter. HD's review program documentation and daily progress reports each working day and QDDPs review program data monthly and daily progress reports each working day.	3/27/26

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W 153	Continued From page 11 An After Visit Summary dated 1/23/26, indicated C2 was seen for red skin areas and the summary indicated the following instructions: right elbow area abrasion vs small area of eczema, right glueteal area likely abrasion. No evidence of infection (cellulitis), both areas are ok to observe without treatment, could consider moisturizing cream or hydrocortisone cream to elbow. During interview on 2/09/26 at 2:55 p.m., director of Oak Street Services (DOSS) stated she was informed of the injury of unknown origin on 1/22/26 in the morning but then was told the registered nurse (RN)-A looked at the areas and did not feel it was an injury of unknown origin. DOSS then stated she was informed C2 went to see the physician the following day and was told it was just eczema and there was no injury of unknown origin. The DOSS stated she was not aware the physician wrote on the referral the area on the buttocks was listed as abrasion vs eczema and with knowing that a GER should have been made and an investigation should have been immediately started for a injury of unknown origin. Facilities Abuse and Reporting policy revised 11/17/25, indicated any employee or volunteer who has reason to believe that a vulnerable adult or minor is being or has been maltreated, regardless of who is responsible for the mistreatment or who has knowledge that a vulnerable adult or minor has sustained a physical injury which is not reasonably explained is required by law to report immediately.	W 153	see above	
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged	W 154		

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W 154	Continued From page 12 violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 (C2) who had abrasions on her back, elbow and buttocks. Findings include: C2's Emergency Data Form (EDF) dated 6/07/2024, indicated she had severe intellectual disability, autism and attention deficit disorder. The EDF further indicated C2 used picture boards to make common requests, is non-verbal used some signs staff must be familiar with, cries out for attention, walks on her own and required 24 hour supervision. A General Events Report (GER) entered on 1/22/26 at 8:42 a.m., by direct support staff (DSS)-A which was deleted on 1/22/26 at 3:10 p.m. by the assistant program director (APD), indicated a injury of unknown was discovered on 1/22/26 at 6:15 a.m. on her right buttock, right elbow and left shoulder and was listed as an abrasion. The summary indicated, "This morning when getting [C2] ready for her shower I noticed a large (approximately 5 in) red mark on her right buttock. I immediately had my coworker come in to observe and we did a body check and found another mark on her right elbow (aprox. 2 in) and also 2 on her left shoulder blade area. To us they appear as rug burn. We contacted evening staff, the household director (HHD)-A which is the person that showered her last night and the marks were not there. Overnight staff reported [C2] had ripped a couple papers off of the front door throughout the night but charted that she slept through the night. I called the mandated	W 154	All clients daily documentation and daily program body check program will be reviewed for the past 30 days to ensure all reports have been reported and thoroughly investigated Director of Oak street services will provide training to program mandated reporters/internal investigators to use the internal checklist (includes interviews, healthcare assessments etc.) to ensure an investigation is investigated properly. The investigation policy will be reviewed for any updates needed and training will be completed on any updates made to the policy. The director of oak street services will review the GER resolution (investigation) and the internal checklist to ensure it was investigated according to policy. Director oaf oak street services is responsible for completion	3/27/26

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W 154	Continued From page 13 reporter line at 6:30 and :7:00 a.m. with no answer so I called the director of Oaks Street Services (DOSS) but also no answer so I sent her a text at 7:15 am.". An After Visit Summary dated 1/23/26, indicated C2 was seen for red skin areas and the summary indicated the following instructions: right elbow area abrasion vs small area of eczema, right glueteal area likely abrasion. No evidence of infection (cellulitis), both areas are ok to observe without treatment, could consider moisturizing cream or hydrocortisone cream to elbow. During interview on 2/09/26 at 2:55 p.m., director of Oak Street Services (DOSS) stated she was informed of the injury of unknown origin on 1/22/26 in the morning but then was told the registered nurse (RN)-A looked at the areas and did not feel it was an injury of unknown origin. DOSS then stated she was informed C2 went to see the physician the following day and was told it was just eczema and there was no injury of unknown origin. The DOSS stated she was not aware the physician wrote on the referral the area on the buttocks was listed as abrasion vs eczema and with knowing that a GER should have been made and an investigation should have been immediately started for a injury of unknown origin. During observation and interview on 2/09/26 at 1:35 p.m., C2 was observed to be sitting in a chair in the main living area with a blanket over her head holding onto newspapers. HHD-A stated C2 likes to do that when she is in the house and stated she will also shred the paper up. HHD-A indicated C1 has had physical aggression towards others and herself and has had a history of elopement but none recent. The	W 154	see above	

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W 154	Continued From page 14 HHD-A stated she had new marks on her elbow, shoulder and buttocks that were reported to her but the next day when she worked she only saw the red mark on her buttocks. HHD-A stated DSS-A and DSS-B filed a GER and was not sure why it has been deleted from the computer system. During interview on 2/10/26 at 2:06 p.m., RN-A stated she observed C2's skin on 1/22/26, and had her sent to the clinic on 1/23/26, since she thought she might have cellulitis due to the warmth and redness on her skin. RN-A stated she was not aware a GER was completed as she does not have access to those reports. While the GER report was pulled up in Therap (electronic software used for documentation and record keeping) RN-A stated the assistant program director (APD) appeared to have deleted the GER. During interview on 2/10/26 at 2:30 p.m. the APD and DOSS, the APD stated she was told by the DOSS to delete the GER due to the RN-A telling her it was not a injury of unknown origin and it was cellulitis or dry skin. The DOSS stated a GER should have been completed in addition to a report to the state after C2 was seen by the physician the following day and diagnosed with right glutei area likely abrasion. Facilities Abuse and Reporting policy revised 11/17/25,. indicated any employee or volunteer who has reason to believe that a vulnerable adult or minor is being or has been maltreated, regardless of who is responsible for the mistreatment or who has knowledge that a vulnerable adult or minor has sustained a physical injury which is not reasonably explained	W 154	see above	

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W 154	Continued From page 15 is required by law to report immediately. The policy further indicated ater a report is made the programs mandated reporter will begin the internal investigation using the checklists included for conducting a fair and impartial investigation.	W 154	see above	
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: The Condition of Participation: 42 CFR 483.460 42 Health Care Services was found when the facility failed to provide nursing services and/or adequate competent staff for C1 who was he was medically cleared to return home and remained at the hosptial for an extended 12 days. Findings include: See W344: The facility failed to provide sufficient licensed nursing staff and/or competent staff to allow 1 of 1 client (C1) to return from the hospital when medically cleared which resulted in an extended hospital stay of 12 days.	W 318	C1 medical record and hospital discharge documentation were reviewed by the facility nurse following return to the facility. The client's condition and care needs were reassessed to ensure appropriate follow-up care and monitoring were implemented. The facility nurse reviewed recent hospitalizations and discharge documentation for all individuals served to ensure that discharge instructions and follow-up care were appropriately implemented. The facility implemented a clarified process for individuals returning from hospitalization or experiencing a significant change in condition which impacts the ability of the facility to safely provide care. If the nurse is not available to conduct an assessment the facility will send an appropriate individual from the facility to determine if client is back to baseline care.	3/27/26
W 344	NURSING STAFF CFR(s): 483.460(d)(2) The facility must employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to provide sufficient licensed nursing	W 344	When a client requires more nursing oversight than is provided on a regular shift per policy , the facility will coordinate with the hospital, case manager, and guardian to determine appropriate options	3/27/26

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W 344	Continued From page 16 staff and/or competent staff to allow 1 of 1 client (C1) to return from the hospital when medically cleared which resulted in an extended hospital stay of 12 days. Findings include: C1's Emergency Data Form (EDF) dated 4/17/24, indicate his date of birth was 9/25/1998. C1 had severe autism, severe intellectual disability, epilepsy, post Strep B with a ventricular peritoneal shunt (medical device used to relieve pressure on the brain caused by excess cerebrospinal fluid) with placement in 2023 due to obstructive hydrocephalus (build up of cerebral spinal fluid.) The EDF indicated C1 was verbal, walked on his own and required 24 hour awake supervision. The EDF further indicated his GA was his emergency contact and medical guardian. During interview on 2/04/26 at 8:01 p.m., GA stated on 10/24/25, C1 was sent to the local emergency department (ED) because he did not feel well, when she arrived he had been waiting there for a long time and after a total of one hour she stated she decided to take him to the hospital in the cities where he had his shunt surgery (preferred hospital). GA stated she was C1's medical decision maker but when she left the ED she was forced to sign an against medical advice form (AMA). GA stated the staff member from the facility (also at the hospital) even agreed he needed immediate attention. GA stated she knew he needed immediate attention because his eyes and pupils were so tiny and he could barley stand and knew something was very wrong and needed to see a neurosurgeon immediately. GA stated when he arrived to the hospital they immediately	W 344	Facility administration and Nurse will review hospital discharge,nursing oversight, medical coordination and change in condition policies and make any updates to the policy that are necessary. the appropriate staff will be trained on any updates The nurse and Director will review hospital discharge documentation and follow-up care monthly for 90 days to ensure procedures and follow up care are followed. written feedback and training will be provided to the facility nurse by DOSS to ensure the understanding of following post hospital discharge procedures. Director of Oak Street services will review nursing documentation every quarter to ensure adherence to policies and procedures Director oaf Oak street services will be responsible for completion. Facility nurse will be retrained on roles, boundaries coordinating care within a team environment and expectations in an ICF setting by the Director of Oak Street Services	

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W 344	Continued From page 17 took him and he had shunt surgery due to his obstruction. The GA indicated because she made that decision, which she felt was in the best interest of C1, she was informed the facility would no longer allow her to take him to appointments and found out they had called adult protection on her. GA stated she has known C1 for 27 years, knows his symptoms of illness and can't understand why they would do this. In addition, GA stated the day he went into the hospital on 10/24/25, he was supposed to have a follow up appointment at his local primary clinic and was unaware of the reason for his appointment change, which delayed his follow until 10/28/25. C1 was not able to go to that appointment because he was in the hospital. Lastly, GA stated she was also upset when C1 was left in the hospital unnecessarily until 12/16/25 when he was medically cleared to return on 12/04/25, and was able to ambulate independently. During interview 2/05/25 at 2:53 p.m., hospital representative registered nurse (RN)-B indicated C1's hospitalization occurred from 10/25/25 to 12/16/25. RN-B stated C1 was medically and physically ready to discharge from the hospital on 12/04/25, but the facility RN-A stated she was on vacation and no one in the facility would be able to accept C1's return which required an unavoidable hospital stay for 12 days. During phone interview on 2/05/26 at 8:55 a.m., C1's primary clinic representative (PCR) stated a nurse from the clinic (RN)-C reached out to the facility on 10/23/25 to follow up on C1's procedure for his shunt and spoke to RN-A who indicated C1's stitches were fine and he had no fever. The PCR then stated their notes indicated RN-C requested to complete an assessment for C1,	W 344	see above	

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W 344	Continued From page 18 with RN-A and she stated she was in a meeting and did not have time. PCR further indicated RN-A was the one who requested the appointment change from 10/24/25 to 10/28/25, per her (RN-A) and GA request. During interview on 2/05/26 at 3:05 p.m. household director (HHD-A) stated when she went to the hospital the first week of December she walked with C1 without a belt and he seemed like he would be able to return back home. During interview on 2/05/26 at 4:14 p.m., facility RN-A stated she informed the hospital case manager a week prior she would be on vacation from 12/05/25 to 12/15/25, and if C1 was going to return from the hospital she would have to let her know the morning of 12/04/25, and she would be leaving by noon. if C1 was going to return it would have to before noon that day otherwise he would have to return after her vacation. Oak Street Admissions Policies and Procedures revised 11/17/2025, to retain placement, individuals admitted will need to continue to meet ICF-DD (Intermediate Care Facilities for Developmentally Disabled) guidelines for active treatment, ambulation, and medical standards. The policy indicated they must be able to ambulate independently, must not need more licensed nursing care than can be provided in a regular shift, refusal to admit a person to LBSA will be based on the evaluation of the person's assessed needs and the lack of capacity to meet the needs of the person. Documentation of the basis of refusal will be provided to the person, the person's legal representative and case manager upon request.	W 344	see above	