MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Pine Ridge Residence

Facility Address:
503 Hallan Avenue #29

Facility City:
Bagley

State: Minnesota
ZIP: 56621
County: Clearwater

Report Number:
HG121001 and HG121002

Date of Visit:
September 19 and 20, 2016

Time of Visit:
9:30 a.m. to 3:30 p.m.
6:00 a.m. to 8:00 a.m.

Date Concluded:
January 12, 2017

Investigator's Name and Title:
Jane Aandal, R.N., Special Investigator

☒ **ICF/IID**

Allegation(s):
It is alleged, that a client was abused when alleged perpetrator #1, restrained the client in the bathroom and propped a chair under the door knob preventing the client from getting out. It is also alleged, that a client was abused when alleged perpetrator #2, restrained the client in the bathroom by shutting the door and holding his/her foot against the door.

- ☒ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- ☒ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, abuse occurred when the alleged perpetrators (AP), AP #1 and AP #2, restricted the client from leaving the bathroom. The facility failed to assess and develop an individual program plan for the client's toileting needs resulting in staff confining the client to the bathroom for toileting.

The client had severe intellectual and developmental disabilities. The client was ambulatory and non-verbal. The client had a history of constipation issues and would go four to five days between bowel movements.

Staff members were interviewed. When the client did not have a bowel movement, the staff would bring the client to the bathroom. Staff instructed the client to stay seated on the toilet, but the client would continue to stand up or fling the bathroom door open with his/her hand. Staff reported AP#1 placed a chair against the bathroom door on two occasions, while the client was supposed to be using the toilet. On one occasion, AP#1 instructed another employee to place the chair against the bathroom door. Over several months, AP#1 placed the chair outside the bathroom door multiple times when the client was inside the bathroom. AP #2 would put a standing tray with some toys on it in front of the client when the client was seated on the toilet, close the bathroom door, then AP #2 would hold his/her foot against the door for about five to ten minutes. This would restrict the client from leaving the bathroom. The client's

comprehensive functional assessment did not address the client's plan or needs for toileting.

AP #1 was interviewed and stated during morning cares s/he put the client in the bathroom and told the client to sit on the toilet. The client did not want to sit, was getting up, and AP #1 instructed the client to sit back down on the toilet. AP #1 stated the dining room chair was not propped under the door knob, but was placed against the outside of the bathroom door. AP #1 would sit on the chair with his/her back to the door. The AP #1 stated the client was in the bathroom for five minutes and had voided on the toilet. The AP stated there were other instances when s/he held her hand on the door knob or placed his/her body against the bathroom door hoping the client would have a bowel movement. AP #1 stated this did prevent the client from leaving the bathroom. The AP stated s/he never asked a staff person to place a dining room chair in front of the bathroom door with the client inside.

AP #2 was interviewed and stated the client did not want to sit on the toilet to have a bowel movement. AP #2 would place a standing tray with toys on it in front of the toilet in hopes the client would stay seated on the toilet. AP #2 stated s/he put her foot against the door so the client would have privacy and would not leave the bathroom. AP #2 stated the client gets upset if s/he stays in the bathroom with the client. The AP stated the client was getting up off the toilet so s/he placed her foot against the door.

The client's guardian stated it has been an ongoing issue with the client using the bathroom. The guardian stated a chair in front of the bathroom door was not acceptable and did not want the situation handled in that manner.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility failed to adequately train staff on resident rights and develop an individual program plan to address the client's toileting needs.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Licensing Rules for Supervised Living Facility (MN Rules Chapter 4665) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665). No state licensing orders were issued.

Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) - Compliance Not Met
The requirements under Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Medication Administration Records
- [x] Assessments
- [x] Facility Incident Reports

Other pertinent medical records:

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ○ Yes ○ No ◉ N/A

Specify: Facility Report

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Non-verbal

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Three

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Nine

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care

☒ Nursing Services

☒ Dignity/Privacy Issues

☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

The Office of Ombudsman for Mental Health and Developmental Disabilities

Bagley Police Department

Clearwater County Attorney

Bagley City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G121	A. BUILDING _____ B. WING _____	C 12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE RESIDENCE	503 HALLAN AVENUE, BOX 29 BAGLEY, MN 56621

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W 000	INITIAL COMMENTS A complaint investigation was conducted to investigate case #HG121001 and #HG121002. As a result, the following deficiencies are issued.	W 000		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the facility was found not to be in compliance with 42 CFR 483.420, the Condition of Participation-Client Protections. The facility failed to implement appropriate interventions along with policies/procedures that protect client's rights. C1 was vulnerable due to the facility's failure to protect C1's rights and the facility failed to ensure the incident was reported to the state agency in a timely manner. Findings include: The Condition level 42 CFR §483.420 Client Protections was not met as evidenced by the following tags: W125 Based on interview and document review, the facility failed to ensure all clients in the home had free access to all areas of the home for 1 of 3 clients (C1) reviewed who was restricted from leaving the bathroom. W149 Based on interview and document review, the	W 122		

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

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

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W 122	Continued From page 1 facility failed to develop their vulnerable adult reporting policy to immediately report allegations of abuse to the administrator. In addition the facility failed to implement their vulnerable adult policy immediately to notify the state agency for 1 of 1 client (C1) reviewed who was restricted from leaving the bathroom. W153 Based on interview and document review, the facility failed to notify the administrator and report to the state agency immediately allegations of abuse of 1 of 1 client (C1) reviewed who was restricted from leaving the bathroom.	W 122		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure all clients in the home had free access to all areas of the home for 1 of 3 clients (C1) reviewed who was restricted from leaving the bathroom. Findings include: C1's clinic documentation dated 2/5/16, indicated C1 was having constipation issues and was only having a bowel movement every four to five days. C1's docusate sodium liquid stool softener was increased to 200 milligrams (mg) twice daily as needed.	W 125		

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W 125	Continued From page 2 C1's medical record was reviewed. C1's comprehensive functional assessment dated 4/1/16, indicated C1 had severe intellectual and developmental disability. C1's comprehensive functional assessment indicated C1 exhibited aggressive behaviors of striking out at others, grabbing eye glasses, and pulling hair when C1 had a request made hat C1 did not want to do such as teeth brushing or staying at the table to eat. On 9/19/16, at 11:08 a.m. the executive director (ED) was interviewed. The ED stated direct support professional (DSP)-D reported to her on 9/12/16, that direct support lead (DSL)-H two weeks earlier had propped a chair against the bathroom door when C1 was in the bathroom. The ED stated DSP-D also reported to her on 9/15/16, that direct support supervisor (DSS)-G had placed a tray in front of C1 with C1's toys on it and a chair in front of the tray and shut the bathroom door. The ED stated it was not acceptable to prop a chair against the bathroom door. On 9/19/16, at 2:34 p.m. DSL-C was interviewed. DSL-C stated C1 wore a brief for bowel and bladder incontinence and was on an every two hour toileting plan. DSL-C stated C1 would show more aggression when constipated. DSL-C stated there were times when C1 would stay seated on the toilet and other times C1 would not. DSL-C stated on 9/13/16, between 8:00 a.m. and 8:15 a.m. she had C1 in the bathroom and C1 would sit on the toilet and then stand up. C1 did not have a bowel movement at this time. DSL-C stated DSS-G then took over C1's care for her when she left the building.	W 125		

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W 125	Continued From page 3 On 9/21/16, at 1:23 p.m. DSP-D stated if you tell C1 to be seated on the toilet C1 would just stand up again. DSP-D stated two or three times in June (date unknown) and once in August (date unknown) he had observed DSL-H place a chair in front of the bathroom door with C1 in the bathroom. DSP-D stated in August DSL-H blocked the bathroom door with the chair for about 15 minutes from 6:00 a.m. until 6:15 a.m. and then let C1 come out. Then DSL-H asked DSP-D to place the chair in front of the bathroom door at 7:15 a.m. as DSL-H was busy and she removed the chair sometime later. DSP-D stated C1 could reach the doorknob from the toilet and would fling the door open repeatedly. DSP-D stated he placed the chair in front of the bathroom door as DSL-H was his supervisor. DSP-D stated he felt placing the chair was wrong so that was why he finally reported to the administrator on 9/12/16. On 9/26/16, at 8:11 a.m. DSS-G was interviewed. DSS-G stated if staff stay in the bathroom with C1, C1 would be physically aggressive by pulling hair and hitting. DSS-G stated C1 was agitated and she did not want C1 to go to the day program being agitated. DSS-G stated after DSL-C left on 9/13/16, she placed C1's plastic TV tray in front of C1 in the bathroom with toys on it and placed a chair in front of the tray as she went to get puzzles from his room. DSS-G stated she was going to sit on the chair to do puzzles with C1 while C1 sat on the toilet. However, when DSS-G returned with the puzzles, C1 had already had a bowel movement on the toilet and she removed the tray and the chair. DSS-G stated the tray and the chair were in place for less than ten minutes. DSS-G stated C1 would also not eat breakfast	W 125		

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W 125	Continued From page 4 that morning due to being constipated. DSS-G stated she was blocking the door so C1 could not exit, but was not trying to harm C1. DSS-G stated she also used her foot against the door as C1 would push the door open with his hand. On 9/27/16, at 9:40 a.m. C1's guardian was interviewed. The guardian stated a chair being placed in front of the bathroom door was not acceptable and did not want the situation handled in that manner. The guardian stated if C1 was not cooperative in the bathroom do not make C1 stay in the bathroom. The guardian stated there had been a team meeting held in August to discuss C1 and a decision was made to not make C1 sit down on the toilet if C1 was incontinent, just change his brief and let C1 leave the bathroom. On 9/28/16, at 11:11 a.m. DSL-H was interviewed. DSL-H stated C1 was non-verbal and ambulatory. DSL-H stated in August (date unknown), C1 had not had a bowel movement for four-five days. DSL-H stated C1 needed to sit on the toilet but kept getting up so DSL-H redirected C1 back to the toilet. DSL-H stated she placed a chair in front of the bathroom door and sat on the chair with her back to the door. DSL-H stated it did prevent C1 from leaving the bathroom. DSL-H stated the objective was to get C1 to sit on the toilet and not leave the bathroom. DSL-H stated about 1/4 of the time when C1 was constipated she would use her body against the door or her hand on the doorknob to keep the bathroom door shut. DSL-H stated she did not intend to hurt C1 and she thought it was an acceptable practice. On 10/10/16, at 3:33 p.m. the qualified intellectual disability professional (QIDP) was interviewed. The QIDP stated it was a right's restriction when	W 125		

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W 125	Continued From page 5 staff would not let C1 come out of the bathroom. The QIDP stated C1 had every right to come out of the bathroom when C1 wanted. The QIDP stated the bathroom restriction was not assessed and staff had implemented this intervention on their own. The QIDP stated there may have been a lack of resident rights training with the staff. The facility's Rights of Persons Served undated policy indicated the facility would ensure that the person's rights would be exercised and protected by all staff. The facility's Home and Community bases services recipient rights undated policy indicated if rights were restricted in any way to protect the health, safety, and well-being of a client, the restriction would be explained, documented, and the restriction would be implemented as required by law so a client could get their rights back as soon as possible.	W 125		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS 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 interview and document review, the facility failed to develop their vulnerable adult reporting policy to immediately report allegations of abuse to the administrator. In addition, the facility failed to implement their vulnerable adult policy to immediately notify the state agency for 1 of 1 client (C1) reviewed who was restricted from leaving the bathroom. Findings include:	W 149		

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W 149	Continued From page 6 The facility's policy Maltreatment of Vulnerable Adults (VA) Reporting and Internal Review Policy revised 4/27/16, indicated it is the policy of this agency to protect the adults served by this program who are vulnerable to maltreatment and to require the reporting of suspected maltreatment of vulnerable adults. As a mandated reporter, if you know or suspect that a vulnerable adult has been maltreated, you must report it and notify Pine Ridge Residence Program Director immediately. If this person is not available or is involved in the alleged or suspected maltreatment, you must report to Pine Ridge Residence Executive Director or Immediate Supervisor On Duty. C1's medical record was reviewed. C1's comprehensive functional assessment dated 4/1/16, indicated C1 had severe intellectual and developmental disability. C1's comprehensive functional assessment indicated C1 exhibited aggressive behaviors of striking out at others, grabbing eye glasses, and pulling hair when C1 had a request made that C1 did not want to do such as teeth brushing or staying at the table to eat. On 9/19/16, at 11:08 a.m. the executive director (ED) was interviewed. The ED stated direct support professional (DSP)-D reported to her on 9/12/16, that direct support lead (DSL)-H two weeks earlier had propped a chair against the bathroom door when C1 was in the bathroom. In addition, the ED stated DSP-D also reported to her that direct support supervisor (DSS)-G had placed a tray in front of C1 with C1's toys on it and a chair in front of the tray and shut the bathroom door. The ED stated it was not acceptable to prop a chair against the bathroom	W 149		

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W 149	Continued From page 7 door. The ED stated she told DSP-D he was a mandated reporter and should have reported immediately. The ED stated she reported to the state after she was told of the two incidents. On 9/21/16, at 1:23 p.m. DSP-D stated if you tell C1 to be seated on the toilet C1 would just stand up again. DSP-D stated two or three times in June (date unknown) and once in August (date unknown) he had observed DSL-H place a chair in front of the bathroom door with C1 in the bathroom. DSP-D stated in August DSL-H blocked the bathroom door with the chair for about 15 minutes from 6:00 a.m. until 6:15 a.m. and then let C1 come out. Then DSL-H asked DSP-D to place the chair in front of the bathroom door at 7:15 a.m. as DSL-H was busy and she removed the chair sometime later. DSP-D stated C1 could reach the doorknob from the toilet and would fling the door open repeatedly. DSP-D stated he placed the chair in front of the bathroom door as DSL-H was his supervisor. DSP-D stated he felt placing the chair was wrong so that was why he finally reported to the administrator on 9/12/16. On 9/26/16, at 8:11 a.m. direct support supervisor (DSS)-G was interviewed. DSS-G stated if staff stay in the bathroom with C1, C1 would be physically aggressive by pulling hair and hitting. DSS-G stated C1 was agitated and she did not want C1 to go to the day program being agitated. DSS-G stated after DSL-C left on 9/13/16, she placed C1's plastic TV tray in front of C1 in the bathroom with toys on it and placed a chair in front of the tray as she went to get puzzles from his room. DSS-G stated she was going to sit on the chair to do puzzles with C1 while C1 sat on the toilet. However, when DSS-G returned with	W 149		

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W 149	Continued From page 8 the puzzles, C1 had already had a bowel movement on the toilet and she removed the tray and the chair. DSS-G stated the tray and the chair were in place for less than ten minutes. DSS-G stated C1 would also not eat breakfast that morning due to being constipated. DSS-G stated she was blocking the door so C1 could not exit, but was not trying to harm C1. DSS-G stated she also used her foot against the door as C1 would push the door open with his hand. On 9/28/16, at 11:11 a.m. DSL-H was interviewed. DSL-H stated C1 was non-verbal and ambulatory. DSL-H stated in August (date unknown), C1 had not had a bowel movement for four-five days. DSL-H stated C1 needed to sit on the toilet but kept getting up so DSL-H redirected C1 back to the toilet. DSL-H stated she placed a chair in front of the bathroom door and sat on the chair with her back to the door. DSL-H stated it did prevent C1 from leaving the bathroom. DSL-H stated the objective was to get C1 to sit on the toilet and not leave the bathroom. DSL-H stated about 1/4 of the time when C1 was constipated she would use her body against the door or her hand on the doorknob to keep the bathroom door shut. DSL-H stated she did not intend to hurt C1 and she thought it was an acceptable practice. On 10/28/16, at 1:20 p.m. the ED was interviewed and stated she was not aware the VA policy did not address immediate notification of the administrator.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G121	A. BUILDING _____ B. WING _____	C 12/22/2016

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PINE RIDGE RESIDENCE	503 HALLAN AVENUE, BOX 29 BAGLEY, MN 56621

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W 153	Continued From page 9 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 notify the administrator and report to the state agency immediately allegations of abuse for 1 of 1 client (C1) reviewed who was restricted from leaving the bathroom. Findings include: The facility's policy Maltreatment of Vulnerable Adults Reporting and Internal Review Policy revised 4/27/16, indicated it is the policy of this agency to protect the adults served by this program who are vulnerable to maltreatment and to require the reporting of suspected maltreatment of vulnerable adults. As a mandated reporter, if you know or suspect that a vulnerable adult has been maltreated, you must report it and notify Pine Ridge Residence Program Director immediately. If this person is not available or is involved in the alleged or suspected maltreatment, you must report to Pine Ridge Residence Executive Director or Immediate Supervisor On Duty. C1's medical record was reviewed. C1's comprehensive functional assessment dated 4/1/16, indicated C1 had severe intellectual and developmental disability. C1's comprehensive functional assessment indicated C1 exhibited aggressive behaviors of striking out at others, grabbing eye glasses, and pulling hair when C1 had a request made that C1 did not want to do such as teeth brushing or staying at the table to	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 10 eat. On 9/19/16, at 11:08 a.m. the executive director (ED) was interviewed. The ED stated direct support professional (DSP)-D reported to her on 9/12/16, that direct support lead (DSL)-H two weeks earlier had propped a chair against the bathroom door when C1 was in the bathroom. In addition, the ED stated DSP-D also reported to her that direct support supervisor (DSS)-G had placed a tray in front of C1 with C1's toys on it and a chair in front of the tray and shut the bathroom door. The ED stated it was not acceptable to prop a chair against the bathroom door. The ED stated she told DSP-D he was a mandated reporter and should have reported immediately. The ED stated she reported to the state after she was told of the two incidents. On 9/21/16, at 1:23 p.m. DSP-D stated if you tell C1 to be seated on the toilet C1 would just stand up again. DSP-D stated two or three times in June (date unknown) and once in August (date unknown) he had observed DSL-H place a chair in front of the bathroom door with C1 in the bathroom. DSP-D stated in August DSL-H blocked the bathroom door with the chair for about 15 minutes from 6:00 a.m. until 6:15 a.m. and then let C1 come out. Then DSL-H asked DSP-D to place the chair in front of the bathroom door at 7:15 a.m. as DSL-H was busy and she removed the chair sometime later. DSP-D stated C1 could reach the doorknob from the toilet and would fling the door open repeatedly. DSP-D stated he placed the chair in front of the bathroom door as DSL-H was his supervisor. DSP-D stated he felt placing the chair was wrong so that was why he finally reported to the administrator on 9/12/16.	W 153		

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W 153	Continued From page 11 On 9/26/16, at 8:11 a.m. direct support supervisor (DSS)-G was interviewed. DSS-G stated if staff stay in the bathroom with C1, C1 would be physically aggressive by pulling hair and hitting. DSS-G stated C1 was agitated and she did not want C1 to go to the day program being agitated. DSS-G stated after DSL-C left on 9/13/16, she placed C1's plastic TV tray in front of C1 in the bathroom with toys on it and placed a chair in front of the tray as she went to get puzzles from his room. DSS-G stated she was going to sit on the chair to do puzzles with C1 while C1 sat on the toilet. However, when DSS-G returned with the puzzles, C1 had already had a bowel movement on the toilet and she removed the tray and the chair. DSS-G stated the tray and the chair were in place for less than ten minutes. DSS-G stated C1 would also not eat breakfast that morning due to being constipated. DSS-G stated she was blocking the door so C1 could not exit, but was not trying to harm C1. DSS-G stated she also used her foot against the door as C1 would push the door open with his hand. On 9/28/16, at 11:11 a.m. DSL-H was interviewed. DSL-H stated C1 was non-verbal and ambulatory. DSL-H stated in August (date unknown), C1 had not had a bowel movement for four-five days. DSL-H stated C1 needed to sit on the toilet but kept getting up so DSL-H redirected C1 back to the toilet. DSL-H stated she placed a chair in front of the bathroom door and sat on the chair with her back to the door. DSL-H stated it did prevent C1 from leaving the bathroom. DSL-H stated the objective was to get C1 to sit on the toilet and not leave the bathroom. DSL-H stated about 1/4 of the time when C1 was constipated she would use her body against the door or her	W 153		

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W 153	Continued From page 12 hand on the doorknob to keep the bathroom door shut. DSL-H stated she did not intend to hurt C1 and she thought it was an acceptable practice. On 10/28/16, at 1:20 p.m. the ED was interviewed and stated she was not aware the VA policy did not address immediate notification of the administrator.	W 153		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure ongoing toileting needs were addressed in the Comprehensive Functional Assessment (CFA) including interventions for 1 of 3 clients (C1) when C1 would not stay seated for toileting. Findings include: C1's clinic documentation dated 2/5/16, indicated C1 was having constipation issues and was only having a bowel movement every four to five days. C1's docusate sodium liquid stool softener was increased to 200 milligrams (mg) twice daily as needed. C1's medical record was reviewed. C1's comprehensive functional assessment dated 4/1/16, indicated C1 had severe intellectual and developmental disability. C1's comprehensive functional assessment indicated C1 exhibited aggressive behaviors of striking out at others,	W 214		

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W 214	Continued From page 13 grabbing eye glasses, and pulling hair when C1 had a request made hat C1 did not want to do such as teeth brushing or staying at the table to eat. However, the CFA failed to address C1's behavior of not staying seated on the toilet to have a bowel movement. In addition, the CFA failed to identify the interventions staff were to use when the behavior was exhibited. On 9/19/16, at 11:08 a.m. the executive director (ED) was interviewed. The ED stated direct support professional (DSP)-D reported to her on 9/12/16, that direct support lead (DSL)-H two weeks earlier had propped a chair against the bathroom door when C1 was in the bathroom. The ED stated DSP-D also reported to her on 9/15/16, that direct support supervisor (DSS)-G had placed a tray in front of C1 with C1's toys on it and a chair in front of the tray and shut the bathroom door. The ED stated it was not acceptable to prop a chair against the bathroom door. On 9/19/16, at 2:34 p.m. DSL-C was interviewed. DSL-C stated C1 wore a brief for bowel and bladder incontinence and was on an every two hour toileting plan. DSL-C stated C1 would show more aggression when constipated. DSL-C stated there were times when C1 would stay seated on the toilet and other times C1 would not. DSL-C stated on 9/13/16, between 8:00 a.m. and 8:15 a.m. she had C1 in the bathroom and C1 would sit on the toilet and then stand up. C1 did not have a bowel movement at this time. DSL-C stated DSS-G then took over C1's care for her when she left the building. On 9/21/16, at 1:23 p.m. DSP-D stated if you tell C1 to be seated on the toilet C1 would just stand	W 214		

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W 214	Continued From page 14 up again. DSP-D stated two or three times in June (date unknown) and once in August (date unknown) he had observed DSL-H place a chair in front of the bathroom door with C1 in the bathroom. DSP-D stated in August DSL-H blocked the bathroom door with the chair for about 15 minutes from 6:00 a.m. until 6:15 a.m. and then let C1 come out. Then DSL-H asked DSP-D to place the chair in front of the bathroom door at 7:15 a.m. as DSL-H was busy and she removed the chair sometime later. DSP-D stated C1 could reach the doorknob from the toilet and would fling the door open repeatedly. DSP-D stated he placed the chair in front of the bathroom door as DSL-H was his supervisor. DSP-D stated he felt placing the chair was wrong so that was why he finally reported to the administrator on 9/12/16. On 9/26/16, at 8:11 a.m. DSS-G was interviewed. DSS-G stated if staff stay in the bathroom with C1, C1 would be physically aggressive by pulling hair and hitting. DSS-G stated C1 was agitated and she did not want C1 to go to the day program being agitated. DSS-G stated after DSL-C left on 9/13/16, she placed C1's plastic TV tray in front of C1 in the bathroom with toys on it and placed a chair in front of the tray as she went to get puzzles from his room. DSS-G stated she was going to sit on the chair to do puzzles with C1 while C1 sat on the toilet. However, when DSS-G returned with the puzzles, C1 had already had a bowel movement on the toilet and she removed the tray and the chair. DSS-G stated the tray and the chair were in place for less than ten minutes. DSS-G stated C1 would also not eat breakfast that morning due to being constipated. DSS-G stated she was blocking the door so C1 could not exit, but was not trying to harm C1. DSS-G stated	W 214		

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W 214	Continued From page 15 she also used her foot against the door as C1 would push the door open with his hand. On 9/27/16, at 9:40 a.m. C1's guardian was interviewed. The guardian stated a chair being placed in front of the bathroom door was not acceptable and did not want the situation handled in that manner. The guardian stated if C1 was not cooperative in the bathroom do not make C1 stay in the bathroom. The guardian stated there had been a team meeting held in August to discuss C1 and a decision was made to not make C1 sit down on the toilet if C1 was incontinent, just change his brief and let C1 leave the bathroom. On 9/28/16, at 11:11 a.m. DSL-H was interviewed. DSL-H stated C1 was non-verbal and ambulatory. DSL-H stated in August (date unknown), C1 had not had a bowel movement for four-five days. DSL-H stated C1 needed to sit on the toilet but kept getting up so DSL-H redirected C1 back to the toilet. DSL-H stated she placed a chair in front of the bathroom door and sat on the chair with her back to the door. DSL-H stated it did prevent C1 from leaving the bathroom. DSL-H stated the objective was to get C1 to sit on the toilet and not leave the bathroom. DSL-H stated about 1/4 of the time when C1 was constipated she would use her body against the door or her hand on the doorknob to keep the bathroom door shut. DSL-H stated she did not intend to hurt C1 and she thought it was an acceptable practice. On 10/10/16, at 3:33 p.m. the qualified intellectual disability professional (QIDP) was interviewed. The QIDP stated the bathroom restriction was not assessed and staff had implemented this intervention on their own.	W 214		

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W 214	Continued From page 16 The comprehensive functional assessment policy was requested and none was provided.	W 214		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess 1 of 1 client (C1) who had identified constipation issues. Findings include: C1's physician's order dated 12/2/15, indicated Diocto liquid 15 milliliters twice daily for constipation. C1's clinic documentation dated 2/5/16, indicated C1 was having constipation issues and was only having a bowel movement every four to five days. C1's docusate sodium liquid stool softener was increased to 200 milligrams (mg) twice daily as needed. C1's medical record was reviewed. C1's comprehensive functional assessment dated 4/1/16, indicated C1 had severe intellectual and developmental disability. C1's comprehensive functional assessment indicated C1 exhibited aggressive behaviors of striking out at others, grabbing eye glasses, and pulling hair when C1 had a request made that C1 did not want to do such as teeth brushing or staying at the table to eat. C1's cover sheet indicated his parents were co-guardians. C1's comprehensive functional assessment indicated C1 used prune juice 2	W 331		

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W 331	Continued From page 17 times a day to promote bowel movements. The assessment lacked any information about constipation issues. C1's physician's order dated 6/15/16, indicated milk of magnesia (MOM) 30 milliliters at bedtime if no bowel movement (BM) after 3 days and as needed for constipation. Senokot 8.6 milligrams 1 tablet twice daily for constipation. Diocto liquid was discontinued. C1's August 2016, medication record and BM record was reviewed. C1 had a BM 8/8/16, however; C1 did not receive MOM on 8/11/16, per the physician's order. C1 had a BM on 8/12/16. C1 had a BM on 8/14/16, however; C1 did not receive MOM on 8/17/16, per the physician's order. C1 had a BM on 8/21/16, however; C1 did not receive MOM on 8/24/16, per the physician's order. C1 received MOM on 8/25/16, and had a BM on 8/26/16. C1's September 2016, medication record and BM record was reviewed. C1 had a BM on 8/29/16, however; C1 did not receive MOM on 9/1/16, per the physician's order. C1 had a BM on 9/3/16. C1 had a BM on 9/15/16, however; C1 did not receive MOM on 9/18/16, per the physician's order. C1 received MOM on 9/19/16. The executive director (ED) was interviewed on 9/19/16, at 11:08 a.m. The ED stated C1 had constipation issues and staff wanted C1 to complete his task on the toilet. The ED stated C1 needed a different BM protocol other than MOM on day three if no BM. C1's clinic note dated 9/21/16, indicated C1's guardian called and reported C1 was still having	W 331		

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W 331	Continued From page 18 issues with constipation. C1's physician ordered Miralax powder 17 grams 1 scoop 1 time a day as needed for constipation. On day 1 if no BM give one scoop, two scoops on day two if no BM, three scoops on day three if no BM, and 1 scoop on day four if no BM. On 10/3/16, at 7:04 p.m. the registered nurse (RN)-K consultant was interviewed. RN-K stated C1 had constipation as a long standing issue. RN-K stated she did not review C1's BM record or any other client's BM record. RN-K stated she had heard from staff that C1 did not like sitting on the toilet and his behaviors coincide with his constipation. RN-K stated she makes her visits at the facility during the day when the clients and supervisory staff are not home. On 10/28/16, at 1:20 p.m. the ED was interviewed and stated there was not a nursing policy to address the client's identified nursing needs.	W 331		

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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. A complaint investigation was conducted to investigate case #HG121001 and #HG121002. As a result, the following correction orders are issued.	5 000	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	

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5 000	Continued From page 1	5 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." 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.	
5 700	MN Statute 144.651 Subd. 14. RES. RIGHTS Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	5 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01012	A. BUILDING: _____ B. WING _____	C 12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE RESIDENCE	503 HALLAN AVENUE, BOX 29 BAGLEY, MN 56621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
5 700	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure all residents in the home were free from maltreatment for 1 of 3 residents (R1) reviewed when R1 was unreasonably confined to the bathroom. Findings include: R1's clinic documentation dated 2/5/16, indicated R1 was having constipation issues and was only having a bowel movement every four to five days. R1's docusate sodium liquid stool softener was increased to 200 milligrams (mg) twice daily as needed. R1's medical record was reviewed. R1's comprehensive functional assessment dated 4/1/16, indicated R1 had severe intellectual and developmental disability. R1's comprehensive functional assessment indicated R1 exhibited aggressive behaviors of striking out at others, grabbing eye glasses, and pulling hair when R1 had a request made of him that he did not want to do such as teeth brushing or staying at the table to eat. On 9/19/16, at 11:08 a.m. the executive director (ED) was interviewed. The ED stated direct support professional (DSP)-D reported to her on 9/12/16, that direct support lead (DSL)-H two weeks earlier had propped a chair against the bathroom door when R1 was in the bathroom. The ED stated DSP-D also reported to her on 9/15/16, that direct support supervisor (DSS)-G had placed a tray in front of R1 with R1's toys on	5 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01012	A. BUILDING: _____ B. WING _____	C 12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE RESIDENCE	503 HALLAN AVENUE, BOX 29 BAGLEY, MN 56621

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5 700	Continued From page 3 it and a chair in front of the tray and shut the bathroom door. The ED stated it was not acceptable to prop a chair against the bathroom door. On 9/19/16, at 2:34 p.m. direct support lead (DSL)-C was interviewed. DSL-C stated R1 wore a brief for bowel and bladder incontinence and was on an every two hour toileting plan. DSL-C stated R1 would show more aggression when constipated. DSL-C stated there were times when R1 would stay seated on the toilet and other times he would not. DSL-C stated on 9/13/16, between 8:00 a.m. and 8:15 a.m. she had R1 in the bathroom and he would sit on the toilet and then stand up. R1 did not have a bowel movement at this time. DSL-C stated DSS-G then took over R1's care for her when she left the building. On 9/21/16, at 1:23 p.m. DSP-D stated if you tell R1 to be seated on the toilet he would just stand up again. DSP-D stated two or three times in June (date unknown) and once in August (date unknown) he had observed DSL-H place a chair in front of the bathroom door with R1 in the bathroom. DSP-D stated in August DSL-H blocked the bathroom door with the chair for about 15 minutes from 6:00 a.m. until 6:15 a.m. and then let R1 come out. Then DSL-H asked DSP-D to place the chair in front of the bathroom door at 7:15 a.m. as DSL-H was busy and she removed the chair sometime later. DSP-D stated R1 could reach the doorknob from the toilet and would fling the door open repeatedly. DSP-D stated he placed the chair in front of the bathroom door as DSL-H was his supervisor. DSP-D stated he felt placing the chair was wrong so that was why he finally reported to the administrator on 9/12/16.	5 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01012	A. BUILDING: _____ B. WING _____	C 12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE RESIDENCE	503 HALLAN AVENUE, BOX 29 BAGLEY, MN 56621

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5 700	Continued From page 4 On 9/26/16, at 8:11 a.m. direct support supervisor (DSS)-G was interviewed. DSS-G stated if staff stay in the bathroom with R1 he will be physically aggressive by pulling hair and hitting. DSS-G stated R1 was agitated and she did not want him to go to the day program being agitated. DSS-G stated after DSL-C left on 9/13/16, she placed R1's plastic TV tray in front of him in the bathroom with toys on it and placed a chair in front of the tray as she went to get puzzles from his room. DSS-G stated she was going to sit on the chair to do puzzles with R1 while he sat on the toilet. However, when DSS-G returned with the puzzles, R1 had already had a bowel movement on the toilet and she removed the tray and the chair. DSS-G stated the tray and the chair were in place for less than ten minutes. DSS-G stated R1 would also not eat breakfast that morning due to being constipated. DSS-G stated she was blocking the door so R1 could not exit, but was not trying to harm R1. DSS-G stated she also used her foot against the door as R1 would push the door open with his hand. On 9/27/16, at 9:40 a.m. R1's guardian was interviewed. The guardian stated a chair being placed in front of the bathroom door was not acceptable and did not want the situation handled in that manner. The guardian stated if R1 was not cooperative in the bathroom do not make him stay in the bathroom. The guardian stated there had been a team meeting held in August to discuss R1 and a decision was made to not make him sit down on the toilet if he was incontinent, just change his brief and let him leave the bathroom. On 9/28/16, at 11:11 a.m. DSL-H was interviewed. DSL-H stated R1 was non-verbal	5 700		

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	01012	A. BUILDING: _____ B. WING _____	C 12/22/2016

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5 700	Continued From page 5 and ambulatory. DSL-H stated in August (date unknown), R1 had not had a bowel movement for four-five days. DSL-H stated R1 needed to sit on the toilet but kept getting up so DSL-H redirected him back to the toilet. DSL-H stated she placed a chair in front of the bathroom door and sat on the chair with her back to the door. DSL-H stated it did prevent R1 from leaving the bathroom. DSL-H stated the objective was to get R1 to sit on the toilet and not leave the bathroom. DSL-H stated about 1/4 of the time when R1 was constipated she would use her body against the door or her hand on the doorknob to keep the bathroom door shut. DSL-H stated she did not intend to hurt C1 and she thought it was an acceptable practice. On 10/10/16, at 3:33 p.m. the qualified intellectual disability professional (QIDP) was interviewed. The QIDP stated it was a right's restriction when staff would not let R1 come out of the bathroom. The QIDP stated R1 has every right to come out of the bathroom when he wanted too. The QIDP stated the bathroom restriction was not assessed and staff had implemented this intervention on their own. The QIDP stated there may have been a lack of resident rights training with the staff. The facility's Rights of Persons Served undated policy indicated the facility would ensure that the person's rights would be exercised and protected by all staff. The facility's Home and Community bases services recipient rights undated policy indicated if rights were restricted in any way to protect the health, safety, and well-being of a client, the restriction would be explained, documented, and the restriction would be implemented as required by law so a client could get their rights back as soon as possible. TIME PERIOD FOR CORRECTION: Twenty-one	5 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01012	A. BUILDING: _____ B. WING _____	C 12/22/2016

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5 700	Continued From page 6 (21) days.	5 700		
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. (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	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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5 815	Continued From page 7 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, facility failed to ensure an alleged incident of staff to client maltreatment reported immediately to the administrator and state agency for 1 of 3 residents (R1) reviewed. Findings include: R1's medical record was reviewed. R1's comprehensive functional assessment dated 4/1/16, indicated R1 had severe intellectual and developmental disability. R1's comprehensive functional assessment indicated R1 exhibited aggressive behaviors of striking out at others, grabbing eye glasses, and pulling hair when R1 had a request made of him that he did not want to do such as teeth brushing or staying at the table to eat. On 9/13/2016, and 9/16/16, the state agency received reports of alleged staff maltreatment R1 that had occurred approximately two to four weeks prior. On 9/19/16, at 11:08 a.m. the executive director	5 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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5 815	Continued From page 8 (ED) was interviewed. The ED stated direct support professional (DSP)-D reported to her on 9/12/16, that direct support lead (DSL)-H two weeks earlier had propped a chair against the bathroom door when R1 was in the bathroom. In addition, the ED stated DSP-D also reported to her that direct support supervisor (DSS)-G had placed a tray in front of R1 with R1's toys on it and a chair in front of the tray and shut the bathroom door. The ED stated it was not acceptable to prop a chair against the bathroom door. The ED stated she told DSP-D he was a mandated reporter and should have reported immediately. The ED stated she reported to the state after she was told of the two incidents. On 9/21/16, at 1:23 p.m. DSP-D stated if you tell R1 to be seated on the toilet he would just stand up again. DSP-D stated two or three times in June (date unknown) and once in August (date unknown) he had observed DSL-H place a chair in front of the bathroom door with R1 in the bathroom. DSP-D stated in August DSL-H blocked the bathroom door with the chair for about 15 minutes from 6:00 a.m. until 6:15 a.m. and then let R1 come out. Then DSL-H asked DSP-D to place the chair in front of the bathroom door at 7:15 a.m. as DSL-H was busy and she removed the chair sometime later. DSP-D stated R1 could reach the doorknob from the toilet and would fling the door open repeatedly. DSP-D stated he placed the chair in front of the bathroom door as DSL-H was his supervisor. DSP-D stated he felt placing the chair was wrong so that was why he finally reported to the administrator on 9/12/16. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 815		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
24G121 Y1	A. Building B. Wing Y2	2/3/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE RESIDENCE	503 HALLAN AVENUE, BOX 29 BAGLEY, MN 56621

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix W0122	Correction	ID Prefix W0125	Correction	ID Prefix W0149	Correction
Reg. # 483.420	Completed	Reg. # 483.420(a)(3)	Completed	Reg. # 483.420(d)(1)	Completed
LSC	02/01/2017	LSC	02/01/2017	LSC	02/01/2017
ID Prefix W0153	Correction	ID Prefix W0214	Correction	ID Prefix W0331	Correction
Reg. # 483.420(d)(2)	Completed	Reg. # 483.440(c)(3)(iii)	Completed	Reg. # 483.460(c)	Completed
LSC	02/01/2017	LSC	02/01/2017	LSC	02/01/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	AW/mm	02/03/2017	11349	02/03/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 12/22/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
01012 Y1	A. Building B. Wing Y2	2/3/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE RESIDENCE	503 HALLAN AVENUE, BOX 29 BAGLEY, MN 56621

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 50700 Reg. # MN Statute 144.651 Subd. 14. LSC	Correction Completed 02/01/2017	ID Prefix 50815 Reg. # MN Statute 626.557 Subd. 3. LSC	Correction Completed 02/01/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) AW/mm	DATE 02/03/2017	SIGNATURE OF SURVEYOR 11349	DATE 02/03/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/22/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: 1IJ912