

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

April 13, 2022

Administrator Preferred Residential Lifestyles-Hcl Inc 108 Ninth Street Windom, MN 56101

RE: Event ID: X2PO11

Dear Administrator:

On March 30, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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 noted one or more deficiencies.

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

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

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

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

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

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: <u>elizabeth.silkey@state.mn.us</u>

Office: (507) 344-2742 Mobile: (651) 368-3593

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

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

Sincerely,

Kim Typon

Kim Tyson, Health Program Representative Senior Program Assurance | Licensing and Certification

Minnesota Department of Health P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-3831

Email: kim.tyson@state.mn.us

PRINTED: 04/13/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER	240244	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	30/2022
INAIVIE OF F	PROVIDER OR SUPPLIER				108 NINTH STREET		
PREFER	RED RESIDENTIAL L	IFESTYLES-HCL INC			WINDOM, MN 56101		
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W 000	INITIAL COMMEN	тѕ	W	000			
	was completed at y complaint investiga compliance with 42 requirements for In Individuals with Intel The following comp SUBSTANTIATED HG244021C (MN8 HG244023C (MN8 HG244025C (MN8 HG244025C (MN8 HG244027C (MN8 HOwever as a result deficiencies were completed to the substitution of t	1773) 1772) 1771) 1770) 81769) 0935) It of the investigation, sited at W149, W153 and acceptable electronic POC, an ir facility may be conducted to antial compliance with the					
LABORATORY	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24G244	B. WING_		C 03/30/2022	
	PROVIDER OR SUPPLIER RED RESIDENTIAL L	IFESTYLES-HCL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 108 NINTH STREET WINDOM, MN 56101	00/00/2022	
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W 000	Continued From pa	ge 1	W 00	00		
W 149	CFR(s): 483.420(d) The facility must depolicies and proced mistreatment, negle This STANDARD is Based on interview facility failed to implipancedures consiste not reporting to the administrator immeabuse for 1 of 1 clie (supervision) for 5 cc) reviewed for all The facility further frompleted required of neglect for 5 of 6 reviewed for neglect Findings include: Review of a Vulnera submitted to the SA	velop and implement written ures that prohibit ect or abuse of the client. It is not met as evidenced by: It and document review, the lement abuse policies and ent with federal regulations by State Agency (SA) and diately for alleged verbal ent (C1) and neglect of care of 6 clients (C2, C3, C4, C5, egations of abuse/neglect. ailed to ensure staff training following an episode clients (C2, C3, C4, C5, C6)	W 14	49		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		24G244	B. WING			C 30/2022
	PROVIDER OR SUPPLIER RED RESIDENTIAL L	IFESTYLES-HCL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 108 NINTH STREET WINDOM, MN 56101		0012022
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W 149	director (PD)-A on 3 indicated she was vevening of 3/4/22. assisted DSP-A with DSP-A made a com [profanity used]". Dispresent when the stindicated she was used what DSP-A was sadisabilities. DSP-B the allegation to any DSP-B continued to The PD reported the administrator on 3/8 administrator on 3/8 administrator submethe SA at that time. Interview on 3/30/22 AD confirmed the atowards C1, had no administrator or the policy. The facility A trained on abuse up Review of the VA re 3/11/22, at 4:20 p.m asleep on 3/10/22, was working was an individuals in the aprequired awake sup The facility Incident indicated on 3/10/22 practical nurse (LPI in the recliner in the (C2, C3, C4, C5, C6 supervision. This with the supervision. This with the supervision.	on of abuse to program (3/8/22, at 7:00 p.m. DSP-B vorking with DSP-A the DSP-B indicated while she in toileting C1 at 5:00 p.m. Imment that C1 "was an SP-B indicated C1 was tatement was made. DSP-B insure if C1 could understand bying, due to his cognitive indicated she did not report yone until 3 days later, and of provide direct care for C1. The allegation to the 3/22, at 1:05 p.m. The itted the allegation of abuse to the SA immediately, per facility indicated all staff are soon hire and annually. Poort submitted to the SA on indicated DSP-D was found at 4:20 p.m The shift she in awake shift and the partment (C2, C3, C4, C5, C6) pervision. Report dated 3/11/22, 2, it was reported that licensed N)-A discovered DSP-D asleep a living room. The individuals 5) required awake	W 14	49		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
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	Individual Abuse Pr 4/2021, included C2 supervision and suptimes when individudated 7/2021, indicaunsupervised in the support person on pindividual was at horizontal was a wa	d 3/29/22, indicated C2's evention Plan (IAPP) dated 2 required 24 hour awake oport person on premises at all lal was home. C3's IAPP ated C3 could be home for zero minutes and oremises at all times when ome. C4's IAPP dated 5/2021, a unsupervised in the home for IAPP dated 11/2021, a unsupervised in the home for IAPP dated 6/2021, indicated a rawake supervision and if a coartment 4 needed to run and a coartment 4 needed to run and a complete date and staff from aware that they were ent as C6 was able to use his a something. The double door at be opened and staff from aware they needed to check I investigation further indicated and falling asleep in apartment and knowledge that it was an arenal investigation also with LPN-A and the program aram director had indicated 4 on 3/10/22, shortly before the D was awake. LPN-A had 4 on 3/10/22, at 4:20 p.m. and p. The internal investigation ould complete her assigned and by 3/21/22, and would ledge C2, C3, C4, C5, and	W	149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24G244	B. WING _		03/3	30/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 108 NINTH STREET WINDOM, MN 56101	1 00/0	50/2022
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W 149	one of the client's or DSP-D and reminded the client's personal leaving for the day's home and thought a reported it to her surface asked why LPN-A dimmediately she inchad already left for she probably should immediately after the On 3/29/22, at 1:03 specialist (QIS)-A creporting any allegas supervisor immediately arter than waiting on 3/29/22, at 3:00 had been working be apartment 4 as som DSP-D stated she wrecliners and became confirmed she had 15-20 minutes DSF following the incident had talked with her on 3/30/22, at 10:1 supervisor (PS)-A cowould be responsible completed the train incident. QIS-A staif training was completed there was confirmed the confirmed	hairs. LPN-A awakened ed her she wasn't to be using I recliners. LPN-A stated shortly after that; she went about the incident and spervisor the next day. When lidn't report the incident dicated all the supervisory staff the day. LPN-A confirmed di have called her supervisor ne incident occurred. p.m. quality improvement onfirmed staff should be ation of abuse/neglect to their stely. QIS-A confirmed she ed LPN-A to report the the stolent of a supervisor immediately until the next day. p.m. DSP-D confirmed she of her self on 3/10/22, in neone had called in sick. It was sitting in one of the client one too comfortable. DSP-D drifted off to sleep about P-D stated she had no training ont, though the regional director about the incident. 6 a.m. QIS-A stated program or the program director (PD)-A le to ensure DSP-D ing requirements following the ted she would follow up to see oleted. At 10:31 a.m., QIS-A is no documentation indicating eted the required training	W 14			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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W 149	Continued From pa	ge 5 Vulnerable Adult revised on	W 149			
W 153	8/20/18, included govulnerable adult, de repeated malicious humiliating, harass as abuse towards a directed facility stafinstances of abuse, exploitation internal instances should be PD or area director to make an initial refor seeing that their appropriate externa also have the option allegations to the M Reporting Center (N team will conduct the If applicable, the coand implement a coto prevent current la lapses in performar STAFF TREATMEN CFR(s): 483.420(d) The facility must en mistreatment, negleinjuries of unknown immediately to the a officials in accordar established proceduths STANDARD is Based on interview facility failed to immabuse for 1 of 1 clie (supervision) for 5 centre of the supervision) for 5 centre of the supervision of the	estured language towards a egrading remarks, use of oral, written or derogatory, ing, or threatening language a vulnerable adult. The policy of to report suspected neglect or financial ly or externally. These immediately reported to the (AD). Mandated reporters are eport and remain responsible report reaches the lagency. The fallibility staff in to directly report any of these innesota Adult Abuse MAARC). The investigating in einvestigation including: g. impany will develop, document orrective action plan designed apses and prevent future ince. IT OF CLIENTS (2) sure that all allegations of ect or abuse, as well as source, are reported administrator or to other ince with State law through	W 153			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
24G244 B. WING	C 03/30/2022
NAME OF PROVIDER OR SUPPLIER PREFERRED RESIDENTIAL LIFESTYLES-HCL INC STREET ADDRESS, CITY, STATE, 108 NINTH STREET WINDOM, MN 56101	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN O PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLÉTION DATE
W 153 Continued From page 6 Agency (SA) for clients reviewed for allegations of abuse/neglect. Findings include: Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1.05 p.m. indicated direct support professional (DSP)-B reported an allegation of abuse to program director (PD)-A on 3/8/22, at 7.00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5.00 p.m. DSP-A made a comment that C1 "was an [profanity used]". DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report the allegation to anyone until 3 days later, and DSP-B continued to provide direct care for C1. The PD reported the allegation to the administrator on 3/8/22, at 1:05 p.m. The administrator submitted the allegation of abuse to the SA at that time. Interview on 3/30/22, at 9:00 a.m. a.m. the facility AD confirmed the above allegation of abuse towards C1, had not been reported to the administrator or the SA immediately, per facility policy. The facility AD indicated all staff are trained on abuse upon hire and annually. Review of the VA report submitted to the SA on 3/11/22, at 4:20 p.m. indicated DSP-D was found asleep on 3/10/22, at 4:20 p.m The shift she was working was an awake shift and the individuals in the apartment (C2, C3, C4, C5, C6) required awake supervision.	

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		24G244	B. WING			C / 30/2022	
	PROVIDER OR SUPPLIER RED RESIDENTIAL L	IFESTYLES-HCL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 108 NINTH STREET WINDOM, MN 56101		00/2022	
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W 153	The facility Incident indicated on 3/10/2 practical nurse (LPI in the recliner in the (C2, C3, C4, C5, C4 supervision. This was on 3/29/22, at 11:4 entering apartment found DSP-D asleed one of the client's personal leaving for the day shome and thought a reported it to her suasked why LPN-A commediately she inchad already left for she probably should immediately after the control of the contro	Report dated 3/11/22, 2, it was reported that licensed N)-A discovered DSP-D asleep eliving room. The individuals 6) required awake as an awake shift. O a.m. LPN-A confirmed 4 on 3/10/22, at 4:20 p.m. and ip in the living room reclined in thairs. LPN-A awakened ed her she wasn't to be using all recliners. LPN-A stated shortly after that; she went about the incident and apervisor the next day. When didn't report the incident dicated all the supervisory staff the day. LPN-A confirmed dinave called her supervisor he incident occurred. p.m. quality improvement onfirmed staff should be ation of abuse/neglect to their ately. QIS-A confirmed she ed LPN-A to report the the, to a supervisor immediately	W 1	53			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER RED RESIDENTIAL L	IFESTYLES-HCL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 108 NINTH STREET WINDOM, MN 56101		
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W 153	PD or area director to make an initial refor seeing that their appropriate externalso have the optionallegations to the MReporting Center (N	e immediately reported to the (AD). Mandated reporters are eport and remain responsible report reaches the al agency. The fallibility staff in to directly report any of these linnesota Adult Abuse MAARC).	W 1			
	The facility must princh while the investigation of	event further potential abuse				
	C1's information codiagnoses including disability, cerebral preuromuscular scoon C1's individual abuse 4/13/21, identified Cobeing able to get his situation, and would is being abused. The C1 as not being able abusive situation. To staff are mandated	over sheet (undated), identified g profound intellectual palsy, cortical blindness and liosis. See risk assessment (RA) dated C1 as presenting a risk of not mself out of an abusive d likely not understand that he he assessment also identified the to remove himself from a the RA further included that all reporters and would observed and/or suspected				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
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PREFER	RED RESIDENTIAL L	IFESTYLES-HCL INC		108 NINTH STREET WINDOM, MN 56101		
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W 155	incidents of abuse. Review of a Vulnera submitted to the SA indicated direct sup reported an allegatidirector (PD)-A on 3 indicated she was vevening of 3/4/22. assisted DSP-A with DSP-A made a comprofanity used]." Dispresent when the stindicated she was under the allegation to any DSP-B continued to Review of an international through 3/10/22 indicated the facility PD on 3/0 on 3/7/22, at 7:00 pitelling C1 that he will interview with DSP-assisted DSP-A with around 4:00 p.m Dispresent when the second control of C8 and C9. That evening, she profanity. DSP-A to say" During the investment of C8 and C9. That even of the investment of C8 and C9. The	ge 9 able Adult (VA) report A on 3/8/22, at 1:05 p.m. port professional (DSP)-B on of abuse to program B/8/22, at 7:00 p.m. DSP-B vorking with DSP-A the DSP-B indicated while she in toileting C1 at 5:00 p.m. ment that C1 "was an DSP-B indicated C1 was tatement was made. DSP-B unsure if C1 could understand aying, due to his cognitive indicated she did not report yone until 3 days later, and in provide direct care for C1. al investigation dated 3/8/22 icated through interview with B/22, DSP-B reported to her .m. that she had heard DSP-A as an (profanity used) .B on 3/8/22, indicated she in toileting C1 on 3/8/22, at DSP-B indicated while they brief, DSP-A called C1 an ound 20 minutes later DSP-B C9 were in the kitchen, when C1 an (profanity used) in When assisting C9 to bed roceeded to blurt out same old C9 to "quit repeating what I estigation DSP-B was asked if cidents of verbal abuse, when while ago (no time date given) 'shut up" because she had SP-A also called C10 "fat".	W 15	5		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE	
W 155	The investigative replaced on suspension was informed on 3/ investigative report for additional staff to procedures were in indicated the plan of facility AD would we regarding a plan of may be termination investigative report the facility staff for the did it included what and all other clients witnessed verbal at the Review of the staffi 3/8/22, indicated D3 1:00 p.m. to 9:00 p. to 10:00 p.m. DSP-3/7/22, but called in Review of the most abuse/maltreatment facility PD, indicated 1/29/22, DSP-B on 1/22/22. Interview on 3/29/22 confirmed the above C1. DSP-B indicated incidents since 9/22 verbally abusive to confirmed DSP-B of shift after she had without the facility PD when the facility PD without the facility PD wit	eport indicated DSP-A was on when the administrator 8/22, at 1:05 p.m. The indicated there was no need raining and policies and applemented. The report further of action taken would be the bork with Human Relations (HR) action for DSP-A of which of employment. The did not include re-educating simely reporting of abuse nor had been done to protect C1 from abuse when DSP-B buse towards C1 and C10. In g schedule from 3/4/22 to SP-A worked on 3/4/22, from m. and DSP-B from 2:00 p.m. A was scheduled to work on	W 1	55			

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	PROVIDER OR SUPPLIER RED RESIDENTIAL L		1	TREET ADDRESS, CITY, STATE, ZIP CODE 08 NINTH STREET VINDOM, MN 56101	1 00/	50/2022
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W 155	open shift because with DSP-A, and shindicated she had be past year, and did needed to be reportimmediately. DSP-I witnessed DSP-A because on abuse since the Interview on 3/29/2 confirmed she had of abuse towards of abuse on the PD indicated she did not administrator until the am. The PD incomposed indicated on abuse not been re-educated on abuse not been re-educated allegation occurred. Interview on 3/30/2 improvement specific conducted the interconfirmed the above she will recommend investigation and for the QIS verified she re-education on abuse not been por DSP-B. The por DSP-B. The past of the past of the por DSP-B. The past of the past	she would have had to work he is mean. DSP-A further been trained on abuse in the not realize allegations of abuse ted to management. Be also confirmed she had eing verbally abusive towards hats in the past several months, he had not been re-educated allegation occurred. 2, at 1:30 p.m. facility PD been aware of the allegations of the allegations of the allegations of the sked DSP-B to fill in an open ecause she was mean. At that hed the PD of the allegation of the towards C1. The PD of the allegation to the he 3/8/22 (the following day) in licated she thought she had 24 allegations to administration mough she had been recently. The PD confirmed she had ed on abuse since the	W 155			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION ING	(>		SURVEY PLETED
		24G244	B. WING			03/3	30/2022
	PROVIDER OR SUPPLIER RED RESIDENTIAL L	FESTYLES-HCL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 108 NINTH STREET WINDOM, MN 56101	- '		
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W 155	had just received the allegation and did not linterview on 3/29/20 confirmed the above abuse towards C1. re-education on abuse immediately to the abuse immediately to the abuse immediately to the abuse immediately to the abuse of allegations of abuse of allegations of abuse of allegations of abuse received training annually, but failed verified DSP-A conton abuse. The ED furtle expected the staff to report the above all immediately, to the The facility's policy 8/20/18, included a language towards are marks, use of report derogatory, humit threatening language staff to report suspensed for financial externally. These in immediately reported (AD). Mandated report in the above and immediately reported (AD). Mandated reported in the above in immediately reported (AD). Mandated reported in the above in immediately reported (AD). Mandated reported in the above in immediately reported (AD). Mandated reported in the above	e training prior to the ot think it was then needed. 2 at 10:30 a.m. the facility AD e findings of the allegation of The AD also confirmed staff use had not been done, and e should be reported administrator and the SA, but AD indicated all staff had been ed on abuse. The did not report the incident use towards C1 immediately dishould have. DSP-B stated g on abuse upon hire and to follow the policy. DSP-B inued to work her shift (total of cident was observed. 1, at 2:30 p.m. the executive ted all staff are trained on the rindicated she would have to follow facility policy and egations of abuse administrator and SA. Vulnerable Adult revised on obuse as being gestured a vulnerable adult, degrading the eated malicious oral, written liating, harassing, or ge. The policy directed facility ected instances of abuse, exploitation internally or	W 1	55			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G244	B. WING			30/2022
	PROVIDER OR SUPPLIER RED RESIDENTIAL L		S 1	TREET ADDRESS, CITY, STATE, ZIP CODE 08 NINTH STREET VINDOM, MN 56101	1 03/-	30/2022
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W 155	their report reaches agency. The fallibili directly report any o	ge 13 Is the appropriate external ty staff also have the option to of these allegations to the use Reporting Center	W 155			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PREFER	RED RESIDENTIAL L	IFFSTYI FS-HCI	H STREET , MN 56101			
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5 000	Initial Comments		5 000			
	In accordance with 144.56 and/or Minn 144.653, this correct pursuant to a surve found that the deficit herein are not corrected shall with a schedule of the Minnesota Departments of the Minnesota Departments of the Minnesota MN Ruindicated below. We several items, failur items will be considered the Lack of compliance item of multi-part ruing assessment of a fin violated during the incorrected. You may request a that may result from orders provided that the Department with notice of assessments.	hether a violation has been compliance with all rule provided at the tag alle number or MN Statute when a rule or statute contains the to comply with any of the lered lack of compliance. It upon re-inspection with any alle will result in the ne even if the item that was initial inspection was the aring on any assessments in non-compliance with these at a written request is made to the hin 15 days of receipt of a cent for non-compliance.				
	On 3/29/22 and 3/3 was conducted. You in compliance with Rules, Chapter 466 Living Facilities (SL	0/22, a complaint investigation ur facility was found to be not requirements of Minnesota 5 requirements for Supervised F).				
	The following comp SUBSTANTIATED: HG244021C (MN8 ² HG244022C (MN8 ² HG244023C (MN8 ²	1673) 1773)				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		01194	B. WING		03/3	
					03/3	0/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S H STREET	STATE, ZIP CODE		
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5 000 5 815	HG244024C (MN87HG244025C (MN87HG244026C (MN87HG244027C (MN80However, as a resulticensing orders were when corrections a date, make a copyelectronically return Elizabeth Silkey elizabeth.silkey@st	1771) 1770) 1769) 1935) It of the invesitgation, related re issued. Ire completed, please sign and of these orders and to:	5 000 5 815			
	(a) A mandated rep believe that a vulne been maltreated, or vulnerable adult has which is not reason immediately report common entry poin vulnerable adult sol admitted to a facility required to report s individual that occu unless: (1) the individual was another facility and reason to believe the maltreated in the properties of the properties of the individual is defined in section 6 clause (4). (b) A person not reconstruction of the clause (4).	orter who has reason to rable adult is being or has who has knowledge that a sustained a physical injury ably explained shall the information to the t. If an individual is a ely because the individual is a, a mandated reporter is not uspected maltreatment of the rred prior to admission, as admitted to the facility from the reporter has a vulnerable adult was evious facility; or ws or has reason to believe a vulnerable adult as 26.5572, subdivision 21, quired to report under the ection may voluntarily				

Minnesota Department of Health

STATE FORM 6899 X2PO11 If continuation sheet 2 of 6

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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(krrr()ra()ra()ra()ra()ra()ra()ra()ra()ra(known or suspected eporter knows or heport has been madd) Nothing in this seporter from also ragency. e) A mandated repleason to believe the 26.5572, subdivision of the repleason to believe the 26.5572, subdivision of the reported error was reported error e	ge 2 ection requires a report of d maltreatment, if the las reason to know that a lade to the common entry point. ection shall preclude a reporting to a law enforcement orter who knows or has last an error under section on 17, paragraph (c), clause make a report under this reporter or a facility, at any time restigation by a lead agency ould determine that the lon 626.5572, subdivision 17, se (5), the reporter or facility common entry point or directly information explaining how the deria under section 626.5572, agraph (c), clause (5). The consider this information when sposition of the report under the lediately report alleged verbal ent (C1) and neglect of care of 6 clients (C2, C3, C4, C5, led State Agency (SA) for allegations of abuse/neglect. Table Adult (VA) report allegations of abuse/neglect. Table Adult (VA) report allegations of abuse/neglect.	5 815			

Minnesota Department of Health

STATE FORM 6899 X2PO11 If continuation sheet 3 of 6

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE C 03/30/2022	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			01194	B. WING		_	
	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFERRED RESIDENTIAL LIFESTYLES-HCL 108 NINTH STREET WINDOM, MN 56101	PREFER	RRED RESIDENTIAL L	IFFSTYLES-HCL				
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an [profanity used]". DSP-B indicated OH was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was asying, due to his cognitive disabilities. DSP-B indicated she did not report the allegation to anyone until 3 days later, and DSP-B continued to provide direct care for C1. The PD reported the allegation to the administrator on 3/8/22, at 1:05 p.m. The administrator submitted the allegation of abuse to the SA at that time. Interview on 3/30/22, at 9:00 a.m. a.m. the facility AD confirmed the above allegation of abuse towards C1, had not been reported to the administrator or the SA immediately, per facility policy. The facility AD indicated all staff are trained on abuse upon hire and annually. Review of the VA report submitted to the SA on 3/11/22, at 4:20 p.m. indicated DSP-D was found asleep on 3/10/22, at 4:20 p.m. The shift she was working was an awake shift and the individuals in the apartment (C2, C3, C4, C5, C6) required awake supervision. The facility Incident Report dated 3/11/22, indicated on 3/10/22, it was reported that licensed practical nurse (LPN)-A discovered DSP-D asleep in the recliner in the living room. The individuals (C2, C3, C4, C5, C6) required awake supervision.	5 815	director (PD)-A on 3 indicated she was vevening of 3/4/22. assisted DSP-A with DSP-A made a comprofanity used]". Depresent when the stindicated she was a what DSP-A was sadisabilities. DSP-B the allegation to any DSP-B continued to The PD reported the administrator on 3/8 administrator submethe SA at that time. Interview on 3/30/22 AD confirmed the atowards C1, had not administrator or the policy. The facility A trained on abuse up Review of the VA re 3/11/22, at 4:20 p.m asleep on 3/10/22, was working was an individuals in the aprequired awake sup The facility Incident indicated on 3/10/22 practical nurse (LPI in the recliner in the (C2, C3, C4, C5, C0 supervision. This work in the supervision. This work is supervision.	3/8/22, at 7:00 p.m. DSP-B working with DSP-A the DSP-B indicated while she h toileting C1 at 5:00 p.m. ment that C1 "was an SP-B indicated C1 was tatement was made. DSP-B unsure if C1 could understand aying, due to his cognitive indicated she did not report yone until 3 days later, and provide direct care for C1. The allegation to the 8/22, at 1:05 p.m. The suitted the allegation of abuse to the estatement was made. DSP-B unsure if C1 could understand aying, due to his cognitive indicated she did not report yone until 3 days later, and provide direct care for C1. The allegation to the selection of abuse to select the allegation of abuse to be a selection of abuse of been reported to the estatement and annually. The shift she in a wake shift and the partment (C2, C3, C4, C5, C6) pervision. The Report dated 3/11/22, 2, it was reported that licensed N)-A discovered DSP-D asleep to living room. The individuals of the provision of the individuals of the care and an awake shift.				

Minnesota Department of Health

STATE FORM K2PO11 If continuation sheet 4 of 6

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		01194	B. WIITO		03/3	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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5 815	found DSP-D aslee one of the client's c DSP-D and reminde the client's personal leaving for the day shome and thought a reported it to her su asked why LPN-A dimmediately she inchad already left for she probably should immediately after the On 3/29/22, at 1:03 specialist (QIS)-A creporting any allega supervisor immediately after the would have expected incident on 3/10/22, rather than waiting. The facility's policy 8/20/18, included govulnerable adult, derepeated malicious humiliating, harass as abuse towards a directed facility staff instances of abuse, exploitation internal instances should be PD or area director to make an initial refor seeing that their appropriate external also have the option allegations to the MReporting Center (Name of the content of the properties of the potion allegations to the MReporting Center (Name of the client).	p in the living room reclined in hairs. LPN-A awakened ed her she wasn't to be using I recliners. LPN-A stated shortly after that; she went about the incident and spervisor the next day. When lidn't report the incident dicated all the supervisory staff the day. LPN-A confirmed di have called her supervisor se incident occurred. p.m. quality improvement onfirmed staff should be ation of abuse/neglect to their stely. QIS-A confirmed she ed LPN-A to report the the store to a supervisor immediately until the next day. Vulnerable Adult revised on estured language towards a signading remarks, use of oral, written or derogatory, ing, or threatening language in vulnerable adult. The policy of to report suspected neglect or financial ly or externally. These immediately reported to the (AD). Mandated reporters are eport and remain responsible report reaches the all agency. The fallibility staff in to directly report any of these linnesota Adult Abuse	5 815			

Minnesota Department of Health

STATE FORM 6899 X2PO11 If continuation sheet 5 of 6

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	JMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		01194	B. WING			C 8 0/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
PREFER	RED RESIDENTIAL L	IFFS I YI FS-HCI	H STREET , MN 56101			
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5 815	Continued From pa	ge 5	5 815			
	(21) days.					
,						

Minnesota Department of Health

STATE FORM K2PO11 If continuation sheet 6 of 6



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 13, 2022

Administrator Preferred Residential Lifestyles-HCL Inc 108 Ninth Street Windom, MN 56101

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: X2PO11

Dear Administrator:

The above facility was surveyed on March 29, 2022 through March 30, 2022 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.

Preferred Residential Lifestyles-Hcl Inc

Page 2

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

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: <u>elizabeth.silkey@state.mn.us</u>

Office: (507) 344-2742 Mobile: (651) 368-3593

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 Elizabeth Silkey. A written plan for correction of licensing orders is not required.

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

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

Sincerely,

Kim Tyson, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Kin Tyson

Saint Paul, Minnesota 55164-0970

Phone: 651-201-3831

Email: kim.tyson@state.mn.us

PRINTED: 04/13/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/S UPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	24G244	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	03/	30/2022
	RED RESIDENTIAL L	IFESTYLES-HCL INC		10	08 NINTH STREET /INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	On 3/29/22 and 3/3 was completed at y complaint investigate compliance with 42	30/22, an abbreviated survey our facility to conduct a tion. Your facility was not in CFR Part 483, subpart I, termediate Care Facilities for	W	000	POC Received- 4-18-22 POC Approved- 5-20-22 Liz Silkey		
							7
	HG244023C (MN81 HG244024C (MN81 HG244025C (MN81 HG244026C (MN81 HG244027C (MN80 However as a result	772) 771) 770) 1769)					
	onsite revisit of your	acceptable electronic POC, an racility may be conducted to ntial compliance with the nattained.					

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

TITLE

ona

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.

	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		24G244	B. WING		C 03/30/2022
	PROVIDER OR SUPPLIER RED RESIDENTIAL L	IFESTYLES-HCL INC		STREET ADDRESS, CITY, STATE, ZIP CO 108 NINTH STREET WINDOM, MN 56101	
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				W 149 To rectify the immediate n program will implement wri policies and procedures that mistreatment, neglect, or absolute. All staff will be retrained requirement to report all absolute immediately to the administrate supervisor and state agency. Ongoing: All incidents of pallegations of abuse/neglect	tten prohibit use of the ined on the ise/neglect rator/ otential
W 149	CFR(s): 483.420(d) The facility must depolicies and proced mistreatment, negle This STANDARD is Based on interview facility failed to imperocedures consist not reporting to the administrator immeabuse for 1 of 1 clic (supervision) for 5 of 60 reviewed for all The facility further completed required of neglect for 5 of 67 reviewed for neglect Findings include: Review of a Vulner submitted to the SA	velop and implement written lures that prohibit ect or abuse of the client. It is not met as evidenced by: v and document review, the lement abuse policies and ent with federal regulations by State Agency (SA) and diately for alleged verbal ent (C1) and neglect of care of 6 clients (C2, C3, C4, C5, legations of abuse/neglect. Taining following an episode clients (C2, C3, C4, C5, C6)	W 1-	reported immediately to the	designated rained on Review of bilities to II required de of emented tor and ctor. ining tation)

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		o	(X3) DATE SURVEY COMPLETED	
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ni.	PROVIDER OR SUPPLIER	LIFESTYLES-HCL INC	24	STREET ADDRESS, CITY, STAT 108 NINTH STREET WINDOM, MN 56101	E, ZIP CODE	03/30/2	2022
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W 149	reported an allegat director (PD)-A on indicated she was evening of 3/4/22. assisted DSP-A wide DSP-A made a cor [profanity used]". Expresent when the sindicated she was what DSP-A was so disabilities. DSP-B the allegation to an DSP-B continued to the PD reported the administrator on 3/3 administrator submethe SA at that time. Interview on 3/30/2 AD confirmed the atowards C1, had not administrator or the policy. The facility at trained on abuse under the VA maddinistrator or the policy. The facility at trained on abuse under the VA maddinistrator or the policy. The facility at a sleep on 3/10/22, was working was a individuals in the arequired awake sum the facility Incident indicated on 3/10/2 practical nurse (LP) in the recliner in the (C2, C3, C4, C5, C3 supervision. This was a sindividual of the recliner in the C2, C3, C4, C5, C3 supervision. This was a sindividual of the recliner in the C2, C3, C4, C5, C3 supervision. This was a sindividual of the recliner in the C2, C3, C4, C5, C3 supervision. This was a sindividual of the recliner in the C2, C3, C4, C5, C3 supervision. This was a sindividual of the recliner in the C2, C3, C4, C5, C3 supervision. This was a sindividual of the recliner in the C2, C3, C4, C5, C3 supervision. This was a sindividual of the recliner in the C2, C3, C4, C5, C3 supervision. This was a sindividual of the recliner in the C2, C3, C4, C5, C3 supervision.	ion of abuse to program 3/8/22, at 7:00 p.m. DSP-B working with DSP-Athe DSP-B indicated while she th toileting C1 at 5:00 p.m. ment that C1 "was an SP-B indicated C1 was tatement was made. DSP-B unsure if C1 could understand aying, due to his cognitive indicated she did not report yone until 3 days later, and to provide direct care for C1. the allegation to the 8/22, at 1:05 p.m. The sitted the allegation of abuse to 2, at 9:00 a.m. a.m. the facility above allegation of abuse to been reported to the the SA immediately, per facility above allegation of abuse the SA immediately, per facility above allegation of abuse the SA immediately, per facility and indicated all staff are pon hire and annually. The shift she in awake shift and the partment (C2, C3, C4, C5, C6) pervision. t Report dated 3/11/22, 2, it was reported that licensed N)-A discovered DSP-D asleep the living room. The individuals 6) required awake	W 1	49			

	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/S UPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		E SURVEY IPLETED
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	RED RESIDENTIAL L	IFESTYLES-HCL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 108 NINTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE
W 149	Investigation printed Individual Abuse Pr 4/2021, included C2 supervision and suptimes when individudated 7/2021, indicaunsupervised in the support person on pindividual was at ho indicated C4 can be zero minutes. C5's indicated C5 can be	it 3/29/22, indicated C2's evention Plan (IAPP) dated required 24 hour awake port person on premises at all al was home. C3's IAPP ated C3 could be home for zero minutes and premises at all times when me. C4's IAPP dated 5/2021, a unsupervised in the home for IAPP dated 11/2021, a unsupervised in the home for IAPP dated in the home for the intervised in the home for the intervised in the home for intervised in the home for the intervised in the intervised in the home for the intervised in the inte	WI	49		
	C6 required 24 hou staff person from aperrand such as make Staff would make Cleaving the apartment of apartment 3 must apartment 3 made a on C6. The internation of C6. The internation	IAPP dated 6/2021, indicated a wake supervision and if a partment 4 needed to run an sting copies downstairs, etc. 6 aware that they were not as C6 was able to use his something. The double door to be opened and staff from aware they needed to check investigation further indicated ed falling asleep in apartment med knowledge that it was an ernal investigation also with LPN-A and the program ram director had indicated 4 on 3/10/22, shortly before D was awake. LPN-A had a on 3/10/22, at 4:20 p.m. and p. The internal investigation buld complete her assigned ag by 3/21/22, and would ledge C2, C3, C4, C5, and P) by 3/21/22.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	50.		CONSTRUCTION		E SURVEY MPLETED
		24G244	B. WING				C /30/2022
	PROVIDER OR SUPPLIER	IFESTYLES-HCL INC		108	EET ADDRESS, CITY, STATE, ZIP CODE NINTH STREET NDOM, MN 56101	_103/	30/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETION DATE
W 149	one of the client's or D and reminded he client's personal re- for the day shortly a thought about the in supervisor the next didn't report the inc immediately she inchad already left for she probably shoul	chairs. LPN-A awakened DSP- r she wasn't to be using the cliners. LPN-A stated leaving after that; she went home and incident and reported it to her day. When asked why LPN-A	Wı	49			
	specialist (QIS)-Ac reporting any allega supervisor immedia would have expecte	p.m. quality improvement onfirmed staff should be ation of abuse/neglect to their ately. QIS-Aconfirmed she at LPN-Ato report the the , to a supervisor immediately until the next day.					
	had been working be apartment 4 as son D stated she was s recliners and becar confirmed she had 15-20 minutes DSI	p.m. DSP-D confirmed she by herself on 3/10/22, in neone had called in sick. DSP-itting in one of the client me too comfortable. DSP-D drifted off to sleep about P-D stated she had no training nt, though the regional director about the incident.					VC
	supervisor (PS)-Ac would be responsible completed the train incident. QIS-Asta if training was com- confirmed there wa	6 a.m. QIS-A stated program or the program director (PD)-A ble to ensure DSP-D ing requirements following the ted she would follow up to see pleted. At 10:31 a.m., QIS-A s no documentation indicating eted the required training nt on 3/10/22.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
		24G244	B. WING	10		1	C /30/2022
	ROVIDER OR SUPPLIER RED RESIDENTIAL L	IFESTYLES-HCL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 108 NINTH STREET WINDOM, MN 56101	1 03	150/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(XS) COMPLETION DATE
W 149	8/20/18, included govulnerable adult, de repeated malicious humiliating, harass as abuse towards a directed facility staffinstances of abuse, exploitation internal instances should be	Vulnerable Adult revised on estured language towards a grading remarks, use of oral, written or derogatory, ing, or threatening language vulnerable adult. The policy f to report suspected, neglect or financial lly or externally. These immediately reported to the	Wı	1149			
W 153	to make an initial refor seeing that their appropriate externa also have the option allegations to the MR eporting Center (Nate will conduct the If applicable, the coand implement a coand implement according to prevent current leapses in performant	l agency. The fallibility staff it to directly report any of these linnesota Adult Abuse MAARC). The investigating me investigation including: g. mpany will develop, document prective action plan designed apses and prevent future ace.	W	153			
	mistreatment, negle injuries of unknown immediately to the a officials in accordar established procede This STANDARD is Based on interview facility failed to immabuse for 1 of 1 clie (supervision) for 5 of	sure that all allegations of ect or abuse, as well as source, are reported administrator or to other nee with State law through ures. Is not met as evidenced by: If and document review, the rediately report alleged verbal ent (C1) and neglect of care of 6 clients (C2, C3, C4, C5, rator and designated State				2.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S UPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		E SURVEY PLETED
		24G244	B. WING			1	C 30/2022
	PROVIDER OR SUPPLIER RED RESIDENTIAL L	IFESTYLES-HCL INC		108 N	ET ADDRESS, CITY, STATE, ZIP CODE NINTH STREET DOM, MN 56101	1 031.	50/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X [§]) COMPLETION DATE
W 153	abuse/neglect. Findings include: Review of a Vulners submitted to the SA indicated direct sup reported an allegatidirector (PD)-Aon 3 indicated she was vevening of 3/4/22. assisted DSP-A wit DSP-A made a com [profanity used]". Dipresent when the sindicated she was a what DSP-A was sadisabilities. DSP-B the allegation to any DSP-B continued to The PD reported the administrator on 3/8 administrator submithe SA at that time. Interview on 3/30/22 AD confirmed the a towards C1, had no administrator or the policy. The facility A trained on abuse up Review of the VA re 3/11/22, at 4:20 p.m as leep on 3/10/22, was working was at	able Adult (VA) report A on 3/8/22, at 1:05 p.m. port professional (DSP)-B on of abuse to program 3/8/22, at 7:00 p.m. DSP-B vorking with DSP-A the DSP-B indicated while she th toileting C1 at 5:00 p.m. SP-B indicated C1 was tatement was made. DSP-B insure if C1 could understand tying, due to his cognitive indicated she did not report tyone until 3 days later, and to provide direct care for C1. the allegation to the 3/22, at 1:05 p.m. The sitted the allegation of abuse to the sA immediately, per facility D indicated all staff are bon hire and annually. port submitted to the SA on the indicated DSP-D was found at 4:20 p.m The shift she to awake shift and the teartment (C2, C3, C4, C5, C6)	W	53	W 153 To rectify immediate need: All staff will be retrained on Polici 12.1 (Administrative Notification Incidents) and their responsibilities regards to reporting all potential allegations of abuse/neglect immediately to the administrator. Ongoing: The program will ensure that all allegations of maltreatment neglect or abuse, as well as injuried of unknown source, are reported immediately to the administrator at to the state agency in accordance with State law through established procedures. Monitoring: The corrections will implemented by the QIDP/Program Director and monitored by the Arc Director. Reporting timeliness with the audited following all episodes of neglect/abuse. Completion Date: 5/4/22	of sin	

	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		SURVEY PLETED
		24G244	B. WING		03/.	30/2022
	PROVIDER OR SUPPLIER RED RESIDENTIAL L	IFESTYLES-HCL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 108 NINTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
W 153	indicated on 3/10/22 practical nurse (LPN in the recliner in the (C2, C3, C4, C5, C6 supervision. This w On 3/29/22, at 11:4 entering apartment found DSP-D aslee one of the client's c D and reminded he client's personal receive for the day shortly a thought about the insupervisor the next didn't report the incimmediately she inchad already left for she probably should immediately after the On 3/29/22, at 1:03 specialist (QIS)-Ac reporting any allegate supervisor immediately and supervisor immediately after than waiting. The facility's policy 8/20/18, included govulnerable adult, derepeated malicious humiliating, harass as abuse towards a directed facility stafinstances of abuse,	Report dated 3/11/22, 2, it was reported that licensed 3)-A discovered DSP-D as leep 2 living room. The individuals 3) required awake as an awake shift. 0 a.m. LPN-A confirmed 4 on 3/10/22, at 4:20 p.m. and p in the living room reclined in hairs. LPN-A awakened DSP- r she wasn't to be using the cliners. LPN-A stated leaving after that; she went home and heident and reported it to her day. When asked why LPN-A hident dicated all the supervisory staff the day. LPN-A confirmed d have called her supervisor he incident occurred. p.m. quality improvement onfirmed staff should be attion of abuse/neglect to their httely. QIS-A confirmed she hed LPN-A to report the the hed LPN-A to report the the he to a supervisor immediately	WI	1.53		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG			E SURVEY MPLETED
		24G244	B, WING				C /30/2022
	PROVIDER OR SUPPLIER RED RESIDENTIAL L	LIFESTYLES-HCL INC		STREET ADDRESS, CITY, STATE, ZIP 108 NINTH STREET WINDOM, MN 56101	CODE		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD I E APPROPR	BE	(XS) COMPLETION DATE
W 153	instances should be PD or area director to make an initial refor seeing that their appropriate externals o have the optionallegations to the MReporting Center (I	e immediately reported to the (AD). Mandated reporters are eport and remain responsible report reaches the al agency. The fallibility staff in to directly report any of these dinnesota Adult Abuse MAARC).	W 1				
	while the investigat This STANDARD i Based on interview facility failed to ens safety were provide a facility staff perso being verbally abus	revent further potential abuse tion is in progress. is not met as evidenced by: w and document review, the ure clients protection and ed for 1 of 1 client (C1), when on witnessed another staff sive towards clients. This had ect all clients residing in					
	C1's information codiagnoses including disability, cerebral pneuromuscular sco C1's individual abus 4/13/21, identified Cobeing able to get his ituation, and would is being abused. The C1 as not being abusive situation. The staff are mandated	over sheet (undated), identified g profound intellectual palsy, cortical blindness and bliosis. See risk assessment (RA) dated C1 as presenting a risk of not imself out of an abusive d likely not understand that he he assessment also identified le to remove himself from a The RA further included that all reporters and would observed and/or suspected					

W 155 Continued From page 9 incidents of abuse. Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B reported an allegation of abuse to program director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-Athe evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-B indicated c1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she he did not report		OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER PREFERED RESIDENTIAL LIFESTYLES-HCL INC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 155 Continued From page 9 incidents of abuse. Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B reported an allegation of abuse to program director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an [profanity used]." DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report			24G244	B. WING			10.5	5 00
W 155 Continued From page 9 incidents of abuse. Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B reported an allegation of abuse to program director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-Athe evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an [profanity used]." DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report					ST 10	8 NINTH STREET	[U3/.	30/2022
incidents of abuse. Review of a Vulnerable Adult (VA) report submitted to the S A on 3/8/22, at 1:05 p.m. indicated direct support professional (DSP)-B reported an allegation of abuse to program director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-Athe evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an [profanity used]." DSP-B indicated C1 was present when the statement was made. DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report the allocations are immediate need: All staff will be retrained on the requirement to provide immediate need: All staff will be retrained on the requirement to provide immediate protection and safety to all clients (including C1) when a episode of abuse/maltreatment has been identified. Ongoing: The facility will ensure actions are immediately taken to prevent further potential abuse while the investigation is in progress. Monitoring: The corrections will be implemented by the QIDP/Program Director and will be monitored by the Area Director. Steps taken to protect the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
DSP-B continued to provide direct care for C1. Review of an internal investigation dated 3/8/22 through 3/10/22 indicated through interview with the facility PD on 3/8/22, DSP-B reported to her on 3/7/22, at 7:00 p.m. that she had heard DSP-A telling C1 that he was an (profanity used). Interview with DSP-B on 3/8/22, indicated she assisted DSP-A with toileting C1 on 3/8/22, at around 4:00 p.m. DSP-B indicated while they were changing C1's brief, DSP-A called C1 an (profanity used). Around 20 minutes later DSP-B stated C1, C8 and C9 were in the kitchen, when DSP-A again called C1 an (profanity used) in front of C8 and C9. When assisting C9 to bed that evening, she proceeded to blurt out same profanity. DSP-A told C9 to "quit repeating what I say" During the investigation DSP-B was asked if there were other incidents of verbal abuse, when DSP-B indicated a while ago (no time date given) DSP-A told C10 to "shut up" because she had been screaming. DSP-A also called C10 "fat".	W 155	Review of a Vulner submitted to the Sa indicated direct sur reported an allegat director (PD)-Aon indicated she was evening of 3/4/22. assisted DSP-A wit DSP-A made a con [profanity used]." I present when the sindicated she was what DSP-A was sadisabilities. DSP-B the allegation to an DSP-B continued to Review of an interm through 3/10/22 incompleted the facility PD on 3 on 3/7/22, at 7:00 p telling C1 that he was interview with DSP assisted DSP-A with around 4:00 p.m I were changing C1's (profanity used). An stated C1, C8 and DSP-A again called front of C8 and C9, that evening, she p profanity. DSP-At say" During the inventer were other in DSP-B indicated a DSP-Atold C10 to	able Adult (VA) report A on 3/8/22, at 1:05 p.m. port professional (DSP)-B ion of abuse to program 3/8/22, at 7:00 p.m. DSP-B working with DSP-Athe DSP-B indicated while she th toileting C1 at 5:00 p.m. ment that C1 "was an DSP-B indicated C1 was tatement was made. DSP-B unsure if C1 could understand aying, due to his cognitive indicated she did not report yone until 3 days later, and to provide direct care for C1. Ital investigation dated 3/8/22 licated through interview with 1/8/22, DSP-B reported to her 1/2 in that she had heard DSP-A ias an (profanity used)B on 3/8/22, indicated she th toileting C1 on 3/8/22, at DSP-B indicated while they is brief, DSP-A called C1 an round 20 minutes later DSP-B C9 were in the kitchen, when 1 C1 an (profanity used) in When assisting C9 to bed roceeded to blurt out same old C9 to "quit repeating what I estigation DSP-B was asked if cidents of verbal abuse, when while ago (no time date given) "shut up" because she had	W 1	55	To rectify immediate need: All sta will be retrained on the requirement provide immediate protection and sa to all clients (including C1) when a episode of abuse/maltreatment has bidentified. Ongoing: The facility will ensure actions are immediately taken to prefurther potential abuse while the investigation is in progress. Monitoring: The corrections will be implemented by the QIDP/Program Director and will be monitored by the Area Director. Steps taken to protect individual will be audited following episodes of neglect/abuse to ensure will be no further abuse while the investigation is in progress.	to afety been event e	

	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		OATE SURVEY OMPLETED
		24G244	B. WING			C 03/30/2022
	PROVIDER OR SUPPLIER	IFESTYLES-HCL INC		STREET ADDRESS, CITY, STATE, Z 108 NINTH STREET WINDOM, MN 56101		13/30/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
	placed on suspension was informed on 3/3 investigative report for additional staff to procedures were imindicated the plan of facility AD would wo regarding a plan of may be termination investigative report the facility staff for todid it included what and all other clients witnessed verbal above the staffir 3/8/22, indicated DS 1:00 p.m. to 9:00 p.m. to 10:00 p.m. DS P-3/7/22, but called in Review of the most maltreatment for DS indicated DSP-A recon 1/27/22 and the facility above to the staffir since 9/21 verbally abusive tow confirmed DSP-B coshift after she had we towards C1 and C10 did not report the vewhen the facility PD shift. DSP-B stated in the staffir and C10 did not report the vewhen the facility PD shift. DSP-B stated in the staffir and C10 did not report the vewhen the facility PD shift. DSP-B stated in the staffir and C10 did not report the vewhen the facility PD shift. DSP-B stated in the staffir and C10 did not report the vewhen the facility PD shift. DSP-B stated in the staffir and c10 did not report the vewhen the facility PD shift. DSP-B stated in the staffir and c10 did not report the vewhen the facility PD shift. DSP-B stated in the staffir and c10 did not report the vewhen the facility PD shift. DSP-B stated in the staffir and c10 did not report the vewhen the facility PD shift. DSP-B stated in the staffir and the	port indicated DSP-A was on when the administrator 8/22, at 1:05 p.m. The indicated there was no need aining and policies and plemented. The report further faction taken would be the rk with Human Relations (HR) action for DSP-A of which of employment. The did not include re-educating imely reporting of abuse nor had been done to protect C1 from abuse when DSP-B use towards C1 and C10. In schedule from 3/4/22 to P-A worked on 3/4/22, from m. and DSP-B from 2:00 p.m. A was scheduled to work on ill. Current staff education on abus P-A, DSP-B and the facility PD eived training on 1/29/22, DSP acility PD on 1/22/22. In at 2:00 p.m. DSP-B, a buse allegations towards I she had witnessed several, that DSP-B had been ards a client. DSP-A also ontinued to finish her work intessed verbal abuse (4 hours). DSP-B stated she rbal abuse until 3 days later, asked her to fill in an open she did not want to work the	-B	55		
ORMCMS-25	67(02-99) Previous Versions (Obsolete Event ID: X2PO11		Facility ID: 01194	If continuation -1 -	11 .614

	FOF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION			
		24G244	B. WING					
	PROVIDER OR SUPPLIER	LIFESTYLES-HCL INC		108	EET ADDRESS, CITY, STATE, ZIP COI NINTH STREET NDOM, MN 56101	ECTION (X5) HOULD BE COMPLET		3012022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	ноиш	BE	(X5) COMPLETION DATE
W 155	open shift because with DSP-A, and slindicated she had lipast year, and did needed to be reportimmediately. DSP-witnessed DSP-AbC10 and other clier DSP-B confirmed s	she would have had to work he is mean. DSP-A further been trained on abuse in the not realize allegations of abuse ted to management B also confirmed she had being verbally abusive towards hats in the past several months, he had not been re-educated allegation occurred.	W 1	55				
	confirmed she had of abuse towards C conversation with I PD indicated she as shift, but refused be work with DSP-A be time, DSP-B inform DSP's-A verbal abuindicated she did not administrator until the am. The PD indicated she did not a to report the and the SA, even the ducated on abuse	2, at 1:30 p.m. facility PD been aware of the allegations 1, when it came up in a DSP-B on 3/7/22, at 7:00. The sked DSP-B to fill in an open ecause she did not want to ecause she was mean. At that ed the PD of the allegation of se towards C1. The PD of treport the allegation to the he 3/8/22 (the following day) in icated she thought she had 24 allegations to administration rough she had been recently. The PD confirmed she had ed on abuse since the						
	improvement special conducted the interconfirmed the above she will recommend investigation and for The QIS verified she re-education on abothe PD or DSP-B. T	2, at 10:00 a.m. facility quality alist (QIS) indicated she nal investigation and e findings. The QIS indicated if a plan of action after the rward this to the facility AD. e did not recommend use and timely reporting for the QIS indicated she did not ning because both employees						

	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	LTIPLE CONSTRUCTION DING			E SURVEY PLETED
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		24G244	B. WING			03/	30/2022
	PROVIDER OR SUPPLIER	LIFESTYLES-HCL INC		STREET ADDRESS, CITY, STATE, ZIP (108 NINTH STREET WINDOM, MN 56101	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	The state of the s	N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
W 155	had just received the allegation and did not be allegation and did not be allegation and allegation on about a llegations of abuse immediately to the	the training prior to the not think it was then needed. 2 at 10:30 a.m. the facility AD or findings of the allegation of The AD also confirmed staff use had not been done, and e should be reported administrator and the SA, but AD indicated all staff had been	W	155			
-	of allegations of all to management an she received training annually, but failed verified DSP-Acon	the did not report the incident ouse towards C1 immediately d should have. DSP-B stated ag on abuse upon hire and to follow the policy. DSP-B tinued to work her shift (total of acident was observed.					
	director (ED) indica abuse. The ED furt expected the staff report the above al immediately, to the The facility's policy 8/20/18, included language towards a remarks, use of rep or derogatory, hum threatening languages taff to report susp neglect or financial	Vulnerable Adult revised on abuse as being gestured a vulnerable adult, degrading peated malicious oral, written iliating, harassing, or ge. The policy directed facility ected instances of abuse, exploitation internally or					
	(AD). Mandated rej	ed to the PD or area director porters are to make an initial responsible for seeing that					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		TE SURVEY
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 108 NINTH STREET WINDOM, MN 56101		3/30/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(XS) COMPLETION DATE
W 155	their report reaches agency. The fallibili directly report any o	ge 13 the appropriate external ty staff also have the option to of these allegations to the use Reporting Center	W 1	155		

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 01194 03/30/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **108 NINTH STREET** PREFERRED RESIDENTIAL LIFESTYLES-HCL **WINDOM, MN 56101** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 5 000 **Initial Comments** 5 000 Signed lic orders received- 4/18/22 Liz Silkey 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 3/29/22 and 3/30/22, a complaint investigation was conducted. 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 found to be SUBSTANTIATED: HG244021C (MN81673) HG244022C (MN81773) HG244023C (MN81772)

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

Jessu Markus

Regional Duector

(X6) DATE 4/18/22 Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ C 01194 03/30/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **108 NINTH STREET** PREFERRED RESIDENTIAL LIFESTYLES-HCL WINDOM, MN 56101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) 5 000 Continued From page 1 5 000 HG244024C (MN81771) HG244025C (MN81770) HG244026C (MN81769) HG244027C (MN80935) However, as a result of the invesitgation, related licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and electronically return to: Elizabeth Silkey elizabeth.silkey@state.mn.us 5 815 MN Statute 626.557 Subd. 3. VA Timing of report. 5 8 1 5 (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. (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.

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ C 01194 03/30/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **108 NINTH STREET** PREFERRED RESIDENTIAL LIFESTYLES-HCL WINDOM, MN 56101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 5 8 1 5 Continued From page 2 5 8 1 5 (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 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 alleged verbal abuse for 1 of 1 client (C1) and neglect of care (supervision) for 5 of 6 clients (C2, C3, C4, C5, C6) to the designated State Agency (SA) for clients reviewed for allegations of abuse/neglect. Findings include: Review of a Vulnerable Adult (VA) report submitted to the SA on 3/8/22, at 1:05 p.m.

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indicated direct support professional (DSP)-B reported an allegation of abuse to program

PRINTED: 04/13/2022 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING 01194 03/30/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **108 NINTH STREET** PREFERRED RESIDENTIAL LIFESTYLES-HCL WINDOM, MN 56101 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 5 815 Continued From page 3 5 815 director (PD)-A on 3/8/22, at 7:00 p.m. DSP-B indicated she was working with DSP-A the evening of 3/4/22. DSP-B indicated while she assisted DSP-A with toileting C1 at 5:00 p.m. DSP-A made a comment that C1 "was an ... [profanity used]". DSP-B indicated C1 was present when the statement was made, DSP-B indicated she was unsure if C1 could understand what DSP-A was saying, due to his cognitive disabilities. DSP-B indicated she did not report the allegation to anyone until 3 days later, and DSP-B continued to provide direct care for C1. The PD reported the allegation to the administrator on 3/8/22, at 1:05 p.m. The administrator submitted the allegation of abuse to the SA at that time. Interview on 3/30/22, at 9:00 a.m. a.m. the facility AD confirmed the above allegation of abuse towards C1, had not been reported to the administrator or the SA immediately, per facility policy. The facility AD indicated all staff are trained on abuse upon hire and annually. Review of the VA report submitted to the SA on 3/11/22, at 4:20 p.m. indicated DSP-D was found asleep on 3/10/22, at 4:20 p.m.. The shift she was working was an awake shift and the individuals in the apartment (C2, C3, C4, C5, C6) required awake supervision.

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The facility Incident Report dated 3/11/22,

(C2, C3, C4, C5, C6) required awake supervision. This was an awake shift.

On 3/29/22, at 11:40 a.m. LPN-A confirmed entering apartment 4 on 3/10/22, at 4:20 p.m. and

indicated on 3/10/22, it was reported that licensed practical nurse (LPN)-A discovered DSP-D asleep in the recliner in the living room. The individuals

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