

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email October 21, 2020

Administrator Shingle Creek Option 5624 73rd Ave No Brooklyn Park, MN 55429

RE: VXJR11 Project Number: HG382004C

Dear Administrator:

On September 23, 2020 through September 30, 2020, an abbreviated survey was conducted to investigate complaint HG382004C. The complaint was substantiated and deficiencies.

In addition, the Condition of Participation- health care services services was found not to be in compliance with 42 CFR 483.460.

## W318 42 CFR § 483.420 Health Care Services

Federal certification deficiencies are delineated on the electronically delivered form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC).

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

Gail Anderson, APM Fergus Falls District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Office: (218) 332-5140

# Shingle Creek Option

## Page 3

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

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by **November 14, 2020**, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

Sincerely,

Any Johour

Amy Johnson, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Telephone: 651-201-4121 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed October 21. 2020

Administrator Shingle Creek Option 5624 73rd Ave No Brooklyn Park, MN 55429

Re: Enclosed State Supplemental Nursing Services Agency Orders - Project Number HG382004C Event ID: VXJR11

Dear Administrator:

On September 23, 2020 - September 30, 2020, a complaint investigation was conducted. The following complaint(s) was found to be substantiated: HG382004C.

Your facility is not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).

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

Please feel free to call me with any questions.

Sincerely,

Any Johour

Amy Johnson, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Telephone: 651-201-4121 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File

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If continuation sheet 1 of 5

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			E SURVEY IPLETED
		01430	B. WING			C 30/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SHINGLE		5624 731	RD AVE NO			
		BROOK	LYN PARK, MN	55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C {EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLETI DATE
5 000	Initial Comments		5 000			
	144.56 and/or Minn 144.653, this correct pursuant to a surve found that the defice herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru indicated below. W several items, failur items will be consid Lack of compliance item of multi-part ru assessment of a fin	nether a violation has been compliance with all rule provided at the tag le number or MN Statute hen a rule or statute contains e to comply with any of the ered lack of compliance. upon re-inspection with any				
	that may result from orders provided that the Department with notice of assessme On 9/23/20 - 9/30/2 was conducted. The	nearing on any assessments non-compliance with these t a written request is made to in 15 days of receipt of a nt for non-compliance. 0, a complaint investigation a following complaint(s) was tiated: HG382004C.				
		compliance with nesota Rules, Chapter 4665 pervised Living Facilities				
5 825	MN Statute 626.557	Subd. 4, VA Reporting.	5 825			
	partment of Health		· · · · · ·			
JRATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Minnesc	ta Department of He	alth			FUR	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		E SURVEY
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		BROOKL	YN PARK, M	N 55429		
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5 825	Continued From page	ge 1	5 825			
	oral report to the co telecommunications similar device shall The common entry reports. To the exten- be of sufficient contra adult, the caregiver, suspected maltreatment the reporter, the tim incident, and any oth reporter believes mit the suspected maltre reporter may disclose in section 13.02, and section 144.335, to the comply with this sub-	ar shall immediately make an mmon entry point. Use of a s device for the deaf or other be considered an oral report. point may not require written nt possible, the report must ent to identify the vulnerable the nature and extent of the ment, any evidence of ent, the name and address of e, date, and location of the her information that the ght be helpful in investigating eatment. A mandated se not public data, as defined d medical records under the extent necessary to division.				
	Based on interview a					-
	aggressive behavior Services Assessmer 2019 - September 20 affecting her ability to	an 2020, identified a history of s. C2's Intensive Support nt (ISSA) dated September 020, identified behaviors o self manage including a owels, plates, phones and				
	dated 6/2020-9/2020	ident and Incident Reports identified the following:				-
	partment of Health	at another client (C4) and				

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
	01430		8. WING		C 09/30/2020	
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5 825	measures included	to a cabinet. Preventative , keep a closer eye on C2	5 825	5 825 The facility's Vulnerable Adults Prevention Plan will be updated		
	when there is only of 7/8/20, C2 had been chair. Another Clien window. C2 stood u chair. C5 moved be from C2. Preventat	one staff in the apartment. In anxious and was sitting in a ft (C5) was looking out the up and pushed C5 into an arm whind the chair to get away tive measures included, keep er when she is in an anxious		specify that all incidents of veri physical aggression between cl be immediately reported to the regardless of amount of harm of The policy will direct the QIDP t all incidents of verbal or physic aggression to the state agency. will receive a copy of the updat	bal or ients will e QIDP, caused. to report al All staff	
	and C2 pushed C4 and walked away.	ng in a chair, C4 walked by with one hand. C4 stumbled Preventative measures ose eye on C2 when peers	·	and retraining on the updated procedure by 11/12/20. New st receive a copy of the updated p part of their initial intake at Alte	aff will policy as	11/14/2
	bathroom. Another of pushed the client. F	ut of her room to use the client walked by and C2 Preventative measures rect C2 while creating a shield ked by.		for People with Autism (Alterna and will be trained on the upda Vulnerable Adults Abuse Prever Plan prior to working their first care shift.	ted ntion	
	7/13/20, C4 was walking around C2 pushed him with two hands Preventative measures included eye on C2 and her distance from in the apartment.	two hands into the counter. res included, keep a close		The updated Vulnerable Adults Prevention Plan will be reviewe quarterly basis by the QIDP and Human Rights Committee, to er	d on a the	
C5	C5. Preventative m	ed near C2 and C2 pushed easures included, continue to /here res are in relation to C2.		continued efficacy. If failures in reporting of verbal or physical aggression are found at that tim	ne, or	
	walked in front of he hands in the chest. included, stay close	walking to her chair, C5 r. C2 pushed C5 with two Preventative measures to aggressing clients so they er in the apartment.		any other time between schedu reviews, the QIDP will be respor for addressing these deficiencie revised Vulnerable Adults Abuse Prevention Plan within three da	nsible s with a	-

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AND PLAN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			E SURVEY IPLETED
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5 825	Continued From pa	age 3	5 825			1
	7/30/20, C2 was be When walking to he client into the table	eing directed to her chair. er chair C2 pushed another . Preventative measures t walk with C2 all the way to				
		ected to stay in her seat and ssion toward others) on C4 xt to her.				
	shoulder causing c Preventative measure	another client on the right lient to fall to the floor. ures included, shadow C2 veen her and other peers.				
, ,	9/20/20, C2 charge into the wall with tw	d toward C4 and pushed him o hands.				
	2:00 p.m. program sometimes C2 had and there was a lot would aggress agai stated for the most stated if C2 was abo	9/24/20, at approximately manager (PM)-B stated aggression when it was loud going on. PM-B stated C2 nst staff or other clients and part it was pretty mild. PM-B but to "charge" staff would tell usually that worked. The PM				
	stated other times C two handed pushed PM-B stated she wa fallen as a result of	22 would aggress and one or or may charge at someone. as unaware if any clients had C2's aggression but stated any injuries to other clients.				
	disability profession "temporary interrupt got aggressive. The themselves betweer	p.m. the qualified intellectual al (QIDP) stated "C2 had a ion procedure" for when she QIDP stated staff put to C2 and other clients and her chair. The QIDP stated if				

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VXJR11

If continuation sheet 4 of 5

	ta Department of H	lealth (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(V3) DAT		
	OF CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
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<b></b>		01430	B. WING		09/	/30/2020	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
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5 825	Continued From p	age 4	5 825				
	incidents of aggres clients had not bee QIDP stated a report there was an injury The QIDP stated if report was needed A facility policy title Prevention Plan, Ir undated, indicated	ed Vulnerable Adults Abuse nternal Reporting System verbal or physical aggression ses not constitute abuse unless					
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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	F		(X3) DATE COMF	E SURVEY PLETED
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AME OF F	PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIP CODE	05/0	012020
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N 000	INITIAL COMMENT		W 000			
	conducted to invest The complaint was	20, an abbreviated survey was igate complaint HG382004C. substantiated and deficiencies , W336, W149, W153		Siter		
-	care services servic compliance with 42			received 11/4/20 approved 11/10/20 POC 11/4/20		
W 149	An full survey was of STAFF TREATMEN CFR(s): 483.420(d)		W 149	W149		
	The facility must de policies and proced	velop and implement written		The facility's Vulnerable Adults Abus Prevention Plan will be updated to specify that all incidents of verbal or physical aggression between clients	will	
	Based on interview facility failed to deve prevention policy we immediately report of	client to client abuse for 1 of 3 d who displayed physically		be immediately reported to the QID regardless of amount of harm cause The policy will direct the QIDP to rep all incidents of verbal or physical aggression to the state agency. All st will receive a copy of the updated po and retraining on the updated	d. bort aff	-
	Prevention Plan, Int undated, indicated v	Vulnerable Adults Abuse ernal Reporting System verbal or physical aggression s not constitute abuse unless s serious harm.		procedure by 11/12/20. New staff w receive a copy of the updated policy part of their initial intake at Alternat for People with Autism (Alternatives and will be trained on the updated (continued o	as ives	
		cident and Incident Reports Didentified the following:			-	
L RATORY		I ER/SUPPLIER REPRESENTATIVE'S SIGN/		TITLE		6) 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.

	T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(VO) 1117-		1	D. 0938-03
	OF CORRECTION	IDENTIFICATION NUMBER:	3	BLE CONSTRUCTION	(X3) D/ CC	TE SURVEY
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SHINGL	E CREEK OPTION			5624 73RD AVE NO BROOKLYN PARK, MN 55429		
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W 149	<ul> <li>-6/25/20, C1 charg shoved the client ir measures included when there is only</li> <li>-7/8/20, C2 had be chair. Another clien window. C2 stood u chair. C5 moved be from C2. Preventa others away from h affect.</li> <li>-7/9/20, C2 was sitt and C2 pushed C4 and walked away.</li> <li>included, keep s cl were around.</li> <li>-7/12/20, C2 came bathroom. Another pushed the client.</li> <li>included, try to re-d for anyone who wal</li> <li>-7/13/20, C4 was w C2 pushed him with Preventative measu eye on C2 and her of in the apartment.</li> <li>-7/15/20, C5 wande C5. Preventative m keep close eye on v</li> <li>-7/18/20, As C2 was walked in front of he hands in the chest.</li> </ul>	ed at another client (C4) and nto a cabinet. Preventative l, keep a closer eye on C2 one staff in the apartment. en anxious and was sitting in a nt (C5) was looking out the up and pushed C5 into an arm chind the chair to get away tive measures included, keep her when she is in an anxious ting in a chair, C4 walked by with one hand. C4 stumbled Preventative measures lose eye on C2 when peers out of her room to use the client walked by and C2 Preventative measures irect C2 while creating a shield	W 149	(W149 cont.) Vulnerable Adults Prevention Plan prior to working first direct care shift. The updated Vulnerable Adults , Prevention Plan will be reviewed quarterly basis by the QIDP and Human Rights Committee, to en continued efficacy. If failures in the reporting of verbal or physical aggression are found at that time any other time between schedul reviews, the QIDP will be respons for addressing these deficiencies revised Vulnerable Adults Abuse Prevention Plan within three day the discovery of the deficiency.	g their Abuse d on a the sure its the e, or ed sible with a	11/14/2

		AND HUMAN SERVICES & MEDICAID SERVICES		·		FOR	D: 10/20/2020 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DA	TE SURVEY MPLETED
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	don't reach each oth -7/30/20, C2 was be When walking to he client into the table. included, staff must chair. -8/9/20, C2 was dire had an ATO (aggress who was seated new -9/16/20, C2 pushed shoulder causing cli Preventative measu closer and get betwe -9/20/20, C2 charge into the wall with two During interview on 9 2:00 p.m. program n sometimes C2 had a and there was a lot g would be aggressive and stated for the m PM-B stated if C2 wa would tell her to sit d The PM stated other aggressive and one may charge at some unaware if any client	her in the apartment. aing directed to her chair. r chair C2 pushed another Preventative measures walk with C2 all the way to acted to stay in her seat and asion toward others) on C4 et to her. d another client on the right ent to fall to the floor. res included, shadow C2 een her and other peers. d toward C4 and pushed him o hands. 9/24/20, at approximately nanager (PM)-B stated aggression when it was loud going on. PM-B stated C2 e against staff or other clients ost part it was pretty mild. as about to "charge," staff lown and usually that worked. times C2 would be or two handed pushed or one. PM-B stated she was s had fallen as a result of stated there had not been	. W 1	49	DEFICIENCY)		
	On 9/24/20, at 2:51 p disability professiona "temporary interrupti	o.m. the qualified intellectual al (QIDP) stated "C2 had a on procedure" for when she QIDP stated staff put			~		

Event ID:VXJR11

Facility ID: 01430

If continuation sheet Page 3 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES		-	FORM	: 10/20/2020 APPROVED 0.0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DAT COM	TE SURVEY
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SHINGLI	E CREEK OPTION			5624 73RD AVE NO BROOKLYN PARK, MN 55429		
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W 149 W 153	themselves betwee directed her to sit in C2 did not sit in her barricade her. On 9/25/20, at 1:44 incidents of aggress clients had not beer QIDP stated the age report incidents of of the SA unless some stated if there was needed. STAFF TREATMEN CFR(s): 483.420(d) The facility must ene mistreatment, negle injuries of unknown immediately to the a officials in accordan established procedu	n C2 and other clients and her chair. The QIDP stated if chair staff would basically p.m. the QIDP stated the sion between C2 and other n reported to the SA. The ency was not required to lient to client altercations to one was injured. The QIDP no injury, then no report was T OF CLIENTS (2) sure that all allegations of ct or abuse, as well as source, are reported dministrator or to other ce with State law through res.	W 149	W153 The facility's Vulnerable Adults Ab Prevention Plan will be updated to direct the QIDP to report all incide verbal or physical aggression to th state agency, regardless of the am of harm caused. All staff will receiv copy of the updated policy and	ents of e ount ve a	
	Based on interview agency failed to noti client to to client abu (C2,C4,C5) reviewed Finding include: C2's Health Care Pla			retraining on the updated procedu 11/12/20. New staff will receive a of the updated policy as part of the initial intake at Alternatives and w trained on the updated Vulnerable Adults Abuse Prevention Plan prior working their first direct care shift.	copy eir ill be to	
	Services Assessmer 2019 - September 2 affecting her ability to	nt (ISSA) dated September 020, identified behaviors o self manage including a owels, plates, phones and		(continued	over)	

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Facility ID: 01430

If continuation sheet Page 4 of 15

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W 153	books/magazines. A review of C2's Act dated 6/2020-9/202 6/25/20, C1 charged shoved the client int measures included, when there is only of 7/8/20, C2 had beer chair. Another Clien window. C2 stood u chair. C5 moved be from C2. Preventat others away from he affect. 7/9/20, C2 was sittin and C2 pushed C4 v and walked away. F included, keep s clo were around. 7/12/20, C2 came of bathroom. Another of pushed the client. F included, try to re-din for anyone who walk	cident and Incident Reports 0 identified the following: d at another client (C4) and to a cabinet. Preventative keep a closer eye on C2 one staff in the apartment. In anxious and was sitting in a t (C5) was looking out the p and pushed C5 into an arm hind the chair to get away ive measures included, keep er when she is in an anxious and in a chair, C4 walked by with one hand. C4 stumbled Preventative measures ose eye on C2 when peers ut of her room to use the client walked by and C2 Preventative measures rect C2 while creating a shield	W 15	3 (W153 cont.) The updated Vul Adults Abuse Prevention Plan reviewed on a quarterly basis QIDP and the Human Rights Co to ensure its continued efficac failures in the reporting of veri physical aggression are found time, or any other time betwee scheduled reviews, the QIDP w responsible for addressing the deficiencies with a revised Vul Adults Abuse Prevention Plan w three days of the discovery of the deficiency.	will be by the ommittee, y. If bal or at that en vill be se nerable within	11/14/2
	Preventative measureye on C2 and her d in the apartment.	two hands into the counter. res included, keep a close listance from other individuals ed near C2 and C2 pushed			-	

		AND HUMAN SERVICES			PRINTED: 10/2 FORM APPF OMB NO. 0938	ROVEİ
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURI COMPLETE C	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMP	X5) PLETION ATE
W 153	Continued From pa	ge 5	W 1	53	-	
:	walked in front of he hands in the chest, included, stay close	walking to her chair, C5 er. C2 pushed C5 with two Preventative measures to aggressing clients so they her in the apartment.				
	When walking to he client into the table.	ing directed to her chair. er chair C2 pushed another Preventative measures walk with C2 all the way to				
		cted to stay in her seat and ssion toward others) on C4 xt to her.				
	shoulder causing cli Preventative measu	another client on the right ient to fall to the floor. ires included, shadow C2 een her and other peers.				
	9/20/20, C2 charged into the wall with two	d toward C4 and pushed him o hands.				
	2:00 p.m. program r sometimes C2 had and there was a lot would aggress again stated for the most stated if C2 was abo her to sit down and stated other times C two handed pushed PM-B stated she was fallen as a result of	9/24/20, at approximately manager (PM)-B stated aggression when it was loud going on. PM-B stated C2 nst staff or other clients and part it was pretty mild. PM-B but to "charge" staff would tell usually that worked. The PM C2 would aggress and one or or may charge at someone. as unaware if any clients had C2's aggression but stated any injuries to other clients.				

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If continuation sheet Page 6 of 15

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION	(X3) DA	D. 0938-039 ATE SURVEY DMPLETED
		•				С
	· · · · · · · · · · · · · · · · · · ·	24G382	B. WING		09	9/30/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
SHINGL	E CREEK OPTION	· ·		5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 153	Continued From pa	ge 6	w 1	53 W318		· · · · · · · · · · · · · · · · · · ·
		p.m. the qualified intellectual		Alternatives will complete	3	
		al (QIDP) stated "C2 had a tion procedure" for when she		comprehensive assessmen		
		QIDP stated staff put		all residents for whom falli		
	themselves betwee	n C2 and other clients and	1	risk by 11/12/20, or within	-	
		her chair. The QIDP stated if chair staff would basically		days of a newly emerging f		
	barricade her.	chair stair would basically		whether permanent or ten	-	11/14/20
				comprehensive assessmen	ts will be	
		p.m. the QIDP stated the		completed by the RN. Whe	never the	
ĺ		sion between C2 and other reported to the SA. The		findings of an assessment s	suggest the	
		t was not required unless		implementation of an inter	vention, that	
	there was an injury	as a result of an altercation.		intervention established at	that time	
		here was no injury, then no		and all direct-care staff wh	o work with	* 1
	report was needed.			the affected client will be t	rained in the	
	A facility policy titled	Vulnerable Adults Abuse		new intervention prior to v	vorking with	
		ernal Reporting System		that resident. Whenever th	e	
		erbal or physical aggression s not constitute abuse unless		assessment establishes a n	eed for a	
	the behavior causes			change to the physical envi	ronment,	
W 318	HEALTH CARE SEP		W 3	18 the QIDP will be responsibl	e for	
	CFR(s): 483.460			initiating the change in the	physical	
	The facility must on	sure that specific health care		environment at that time.	:	
	services requirement			The office of the table	ata a sunt t	
-				The efficacy of the interven	1	
				assessed on a quarterly bas		
		not met as evidenced by:		following significant change		
		on, interview and document		mobility of a client. If at tha		
	review, the Condition	n of Participation at 42 CFR		interventions are judged to		
		services was not met. The		insufficient to reduce the ri		
		ure thorough assessment of interventions to reduce		another assessment will be		
		for 1 of 1 clients (C1)		within two weeks of that ju	+	
	reviewed for Falls.			and modified, or new interv	ventions	
1				established.	-	

Facility ID: 01430

If continuation sheet Page 7 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/20/2020 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	CON	E SURVEY IPLETED
		24G382	B. WING	۰ 			C 30/2020
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SHINGLE	E CREEK OPTION			1	624 73RD AVE NO BROOKLYN PARK, MN 55429		
(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 R CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 318	Continued From page	ge 7	. W 3	318	1		
	Findings include:						
W 331	implement practices 1 of 1 clients (C1) re		W 3	331	W331		
		ovide clients with nursing nee with their needs.			Alternatives will complete a comprehensive assessment of falls all residents for whom falling is a kr	l l	
	Based on observati review, the agency f comprehensive asso develop and implem	essment of falls and failed to ent interventions to reduce s for 1 of 1 clients (C1)			risk by 11/12/20, or within ten cale days of a newly emerging falling risk whether permanent or temporary. comprehensive assessments will be completed by the RN. Whenever the findings of an assessment suggest th	k, The e ne	
	Findings include:				implementation of an intervention, intervention established at that time		
	(ISSA) dated 9/10/19 coordination along w placed him at risk if indicated C1 had a p 8/21/19, at which tim recommended to co when walking long d The physical therapy	ntrol speed and offer support istances or in the community. / assessment also indicated of shower for bathing. The			and all direct-care staff who work w the affected client will be trained in new intervention prior to working w that resident. Whenever the assessment establishes a need for a change to the physical environment, the QIDP will be responsible for initiating the change in the physical environment at that time.	the rith	
I		cident Reports dated 6/22/20 C1 experienced a total of 25			(continued or	ver)	

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If continuation sheet Page 8 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 10/20/2020 M APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) D/	D. 0938-0391 ATE SURVEY DMPLETED
		24G382	B. WING		0	C 9/30/2020
NAME OF	PROVIDER OR SUPPLIER	)i		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	///////////////////////////////////////
SHINGL	E CREEK OPTION			5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 331	-6/22/20, C1 was at missed the chair an included, monitor C -6/30/20, C1 was st and slipped to his bo on the arm rest of th measures included, morning when using -7/10/20, C1 walked heard a thump and bottom. Preventative monitor C1 when go -7/12/20, C1 stood u started walking, lost bottom. C1 hit his ba neck on the wall. Pro- shadowing C1 close apartment. -7/17/20, Staff were hammock and C1 lo C1 to the ground ho Preventative measure staff when putting C -7/21/20, C1 was wa and started to fall. S -7/30/20, C1 stood u his bottom. Preventative shadow C1 closely w	tempting to sit at the table, d fell. Preventative measures 1 closely for imbalance. anding up from the commode ottom. C1 scraped his elbow ne commode. Preventative monitor C1's gait in early g commode. I into his room for a nap. Staff found him on the floor on his e measures included, closely bing into his room alone. up from his chair abruptly, his balance and fell on his ack, shoulder blades and eventative measures included ly when moving in the attempting to put C1 in the st his balance. Staff lowered	W 33	(W331 cont.) The efficacy of the interventions will be assessed on a quarterly basis or following signific changes in the mobility/stability of client. If at that time the interventi are judged to be insufficient to red the risk of falling, another assessm will be conducted within two week that judgement and modified, or n interventions established.	ant a ons uce ent s of	11/11/2-2

Facility ID: 01430

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	): 10/20/2020 APPROVED ), 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DA	TE SURVEY MPLETED
	,	24G382	B. WING	3		09	C /30/2020
NAME OF	PROVIDER OR SUPPLIER	9		STRE	ET ADDRESS, CITY, STATE, ZIP	and the second sec	
SHINGL	E CREEK OPTION				73RD AVE NO OKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	TX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
W 331	and lost his balance second time when a up. -8/13/20, C1 fell att chair. Preventative use of black shoes -8/19/20, C1's motion entered his room an floor was wet so sta Preventative measur mat "or something" there was an inappu- -8/20/20, C1 got up slipped off and he to his knees. Preventat monitor C1's gait white -8/20/20, C1 was we bed, slipped on the his knees. Preventat monitor C1 when white -8/21/20, C1 was all Preventative measur cleaned regularly to -8/22/20, Staff heard from C1's room. Sta of his bedroom. Sta fell three more time get their footing. C1 Preventative measures	tting clothes out of his closet e and fell. C1 then fell a staff were trying to assist him empting to sit on a kitchen measures included, consider instead of brown shoes. on sensor sounded and staff nd found C1 on the floor. C1's aff assumed he slipped. ures included, C1 may need a to provide more grip when ropriate urination. from a chair, C1's shoe ripped forward and landed on ative measures included, hen he got up quickly. alking in his room toward his tile floor and fell forward onto tive measures included alking on slippery flooring. one in his room when he fell. ures included, floor would be avoid slippery surface. d loud vocalizations coming aff found C1 sitting on the floor ff tried to assist him up and he s due to staff not being able to 's floor was wet from urine. ires included, frequently check	W	331			
		nonitor when awake in room. and ran to bathroom and fell.	-			<b>11</b>	
DRM CMS-25	67(02-99) Previous Versions	•		Facility ID	: 01430 If (	continuation sheet F	Page 10 of 15

		AND HUMAN SERVICES				FOF	ED: 10/20/2020 RM APPROVED IO: 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		24G382	B. WING	š		0	C 9/30/2020
NAME OF	PROVIDER OR SUPPLIER		_L		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	515072020
SHINGLI	E CREEK OPTION				5624 73RD AVE NO		
(X4) ID	SI INAAA DV STA	TEMENT OF DEFICIENCIES			BROOKLYN PARK, MN 55429		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	-D 8E	(X5) COMPLETION DATE
W 331	Continued From page	ne 10	w a	>21	4		
		res included, monitor C1	VV 3	101	1		
	found sitting on the	sensor sounded and he was floor in urine. Preventative closely monitor C1 when he rnight shift.					
	client and fell and ar	bulating, bumped into another nd bumped his head. res included, shadow C1 g around.					
	-9/8/20, C1 was wall bathroom, tripped ar	king with staff from the nd fell.					
	-9/9/20, C1 was in th slipped and fell.	ne bathroom with staff,					
	-9/12/20, C1 fell com Preventative measur bathroom for him.	ning out of the shower. res included, dry floor of					
	fell with the chair ont unsure what caused	ated at the dining table and o his right side. Staff were the fall. Preventative make sure he was seated					
	Sunday by two staff a	ught to the hospital on after staff noticed a swollen ion during the morning.			-		
	C1's right ear. Staff s hit his head on an ob	ved heavy redness around uspected he had fallen and ject. Preventative measures check for injury thoroughly, /.					

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		AND HUMAN SERVICES			·	FOR	D: 10/20/202 MAPPROVE D: 0938-039
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,				TE SURVEY
		24G382	B, WING	i		09	C 9/30/2020
NAME OF I	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP COE 324 73RD AVE NO	DE	
SHINGL	E CREEK OPTION			•	ROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 331	thump and found hi	ge 11 his room alone. Staff heard a im on the floor. Preventative , monitor C1 closely when in	W	331			
	dated 9/15/20 indicated 9/15/20 indicated fails in the last 24 indicated C1 had be and evaluation and with recommendation	pital Discharge Summary, ated C1 had autism,was deaf, rienced an increased number 4 hours. The summary een admitted for observation was diagnosed with a stroke, on from physical therapy for assist with ambulation at all					
	skills instructor (LSI bathroom, LSI-A lef briefly, then returne C1 ambulated back was wearing a towe Wet foot prints were leading out into the	on 9/24/20, at 9:54 a.m. living I)-A escorted C1 to the t C1 in the bathroom alone d with a towel. At 10:11 a.m. t to his room with LSI-A. C1 el and did not have shoes on. e noted on the bathroom floor common area. At 10:16 a.m. e kitchen while LSI-A held a shirt.		ran - ray			• •
	member (FM)-A sta and stated he/she f with him on that. FN belt they were using about the belt last y						
-	stated before C1 we unstable and his ba stated staff guided ( bathroom. In regard	9/24/20, at 1:32 p.m. LSI-A ent to the hospital he was lance was not good. LSI-A C1 whenever he went to the I to fall interventions, LSI-A o have C1 walk with staff			lity ID: 01430 If cont	inuation sheet	

		AND HUMAN SERVICES				FOR	D: 10/20/2020 MAPPROVED O. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	ATE SURVEY
E .		24G382	B. WING				C 9/30/2020
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		010012020
SHINGL	E CREEK OPTION				4 73RD AVE NO OOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	because he was so belt was being used the premises. LSI-A interventions were la staff to document pr A review of the kiosl "When ambulatory r possible obstacles a balance and suppor 2017-2018. On 9/24/20, at 1:36 (PM)-A stated C1 was PM-A stated one mo fallen and gone to th days later. PM-A stated facility decided to do PM-A stated on eve PM-A stated C1 had was checked on eve PM-A stated when C wherever he went. On 9/24/20, at 2:22 p stated C1 had many hospitalized on 9/13/ hospitalized on 9/13/ hospi	fast. LSI-A stated a transfer only when C1 was outside further stated fall boated on the kiosk (used for ogress notes). A indicated, monitor for falling, nonitor for steady gait and and in tricky terrain, provide t." The tasks were dated op.m. the program manager as not stable and he "trips." orning he came in and C1 had e hospital and returned two ted after hospitalization, the a one to one staff for C1. a camera in his room and ry two hours while in bed. 1 was up staff followed him op.m. registered nurse (RN)-A falls recently and was 20. RN-A stated following the as assessed by physical the last facility assessment e in December of 2019 and d a definite decrease in	W 3	31		· · ·	

If continuation sheet Page 13 of 15

		AND HUMAN SERVICES			FORM	): 10/20/2020 A APPROVED ), 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		24G382	B. WING		09	C /30/2020
NAME OF	PROVIDER OR SUPPLIER	. · · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CODE		
SHINGL	E CREEK OPTION			5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	there had been a la	ck of staff and a lack of	W 33	31		
W 336	incident reports wer reviewed them and The QIDP stated no comprehensive ass QIDP stated when 0 should have been u implemented becau trained how to use i During a telephone a.m. C1's clinic RN made the physician The clinic RN stated from facilities when she could not find a indicating the agend falls. An agency policy re requested but not re NURSING SERVIC CFR(s): 483.460(c) Nursing services mi certified as not need review of their healt quarterly or more fro client need. This STANDARD is Based on interview facility's nurse failed	p.m. the QIDP stated the re filled out by staff and he discussed them with RN-A. o one had completed a ressment of C1's falls. The C1 was awake a transfer belt used but had not been use staff had not been properly it. interview on 9/24/20, at 9:35 stated the agency had not aware C1 had so many falls. d they usually received notices clients were falling and stated my notes in the clinic records by had notified them of C1's lated to client falls was eceived. ES	W 33	36		

Event ID: VXJR11

Facility ID: 01430

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	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	. 0938-039 E SURVEY MPLETED
		24G382	B. WING		00	C /30/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 05	50/2020
SHINGLI	E CREEK OPTION	•		5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W <sup>.</sup> 336	Continued From pa	ge 14	W 336	5 W336		
		are status. In addition failed to		The RN will conduct guarterly rev	iour	
	ensure a yearly phy physician for 1 of 3	sical was completed by the clients (C1).		of client health status and report		
	•••			findings of those reviews to the C		
1	Findings include:			upon completion. The QIDP will b	e	
	C1's Health Care Plan 2020, identified diagnosis that included Autism, Mental Retardation, Hydrocephalus and Bruxism. The Health Care Plan identified areas to include medical, dental, hearing, vision, behaviors and medication use. The care plan was reviewed by registered nurse (RN)-A January 2020. The signature lines for April and July of 2020 were blank. The Physical Health portion of the Health Care Plan indicated C1's last physical exam was completed 8/6/19, and was due August 2020. Further review of the medical record lacked evidence of a physical exam completed by a physician since 8/6/19. The Health Care Plan indicated a physical therapy			responsible for ensuring the revie completed on a quarterly basis. T initial quarterly health status revi will be completed by 11/12/20 ar every 90 days thereafter.	he ews	11/12/2
	but did not address During interview on stated C1 was due to because of COVID- on it, even though C for other appointme unsure if C1 had se year. In regard to the stated she had not st	en completed August 2019, C1's falls since 2019. 9/29/20, at 2:23 p.m. RN-A for his annual physical but 19 they agency had held off C1 had been out of the facility nts. RN-A stated she was en his physician since last he quarterly review, RN-A signed off on the completion				
	of C1's quarterly rev knows" what's going	views because she "just g on.				

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Facility ID: 01430

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If continuation sheet Page 15 of 15

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		OATE SURVEY	
			A. BUILDING:			C	
		01430	B. WING			30/2020	
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
HINGLE	CREEK OPTION		RD AVE NO LYN PARK, MN	55429			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
5 000	Initial Comments		5 000				
	144.56 and/or Minn 144.653, this correct pursuant to a surver found that the defict herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru indicated below. W several items, failur items will be consid Lack of compliance item of multi-part ru assessment of a fir	hether a violation has been compliance with all a rule provided at the tag ule number or MN Statute (hen a rule or statute contains re to comply with any of the lered lack of compliance. a upon re-inspection with any					
	that may result from orders provided that the Department with notice of assessme On 9/23/20 - 9/30/2 was conducted. The	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance. (0, a complaint investigation e following complaint(s) was ntiated: HG382004C.					
		n compliance with nnesota Rules, Chapter 4665 upervised Living Facilities					
5 825	MN Statute 626.55	7 Subd. 4. VA Reporting.	5 825				

	IT OF DEFICIENCIES	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or contraction	IDENTIFICATION NOMBER.	A. BUILDING:			
		01430	B. WING			C 30/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SHINGLE	E CREEK OPTION		RD AVE NO _YN PARK, MN	55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
5 825	Continued From pa	ige 1	5 825			
	oral report to the co telecommunications similar device shall The common entry reports. To the extend be of sufficient com- adult, the caregiver suspected maltreate previous maltreate the reporter, the tim incident, and any of reporter believes may the suspected malt reporter may disclo in section 13.02, ar section 144.335, to comply with this suf This MN Requirement by: Based on interview agency failed to not client to to client ab (C2,C4,C5) reviewed Finding include: C2's Health Care P	ent is not met as evidenced and document review the tify the state agency (SA) of buse for 3 of 3 clients ed for abuse. lan 2020, identified a history o				
	aggressive behavior Services Assessme 2019 - September 2 affecting her ability	ors. C2's Intensive Support ent (ISSA) dated September 2020, identified behaviors to self manage including a bowels, plates, phones and				
		cident and Incident Reports 20 identified the following:				
	6/25/20, C1 charge	d at another client (C4) and				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		01430	B. WING			C 30/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SHINGLI	E CREEK OPTION		RD AVE NO _YN PARK, MN	55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
5 825	shoved the client in measures included, when there is only of 7/8/20, C2 had bee chair. Another Clier window. C2 stood u chair. C5 moved be from C2. Preventation others away from h affect. 7/9/20, C2 was sittin and C2 pushed C4 and walked away. included, keep s cl were around. 7/12/20, C2 came of bathroom. Another pushed the client. I included, try to re-d for anyone who wal 7/13/20, C4 was wa C2 pushed him with Preventative measu eye on C2 and her in the apartment.	to a cabinet. Preventative , keep a closer eye on C2 one staff in the apartment. In anxious and was sitting in a at (C5) was looking out the up and pushed C5 into an arm whind the chair to get away tive measures included, keep er when she is in an anxious ing in a chair, C4 walked by with one hand. C4 stumbled Preventative measures ose eye on C2 when peers out of her room to use the client walked by and C2 Preventative measures irect C2 while creating a shield ked by. alking around the apartment. In two hands into the counter. Jures included, keep a close distance from other individuals	ł			
	C5. Preventative m keep close eye on v 7/18/20, As C2 was walked in front of he hands in the chest. included, stay close	red near C2 and C2 pushed neasures included, continue to where res are in relation to C2 walking to her chair, C5 er. C2 pushed C5 with two Preventative measures to aggressing clients so they her in the apartment.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01430		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/30/2020	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		1 00,	00/2020
NAME OF I	FROVIDER OR SUFFLIER		RD AVE NO	TATE, ZIF CODE		
SHINGLI	E CREEK OPTION		LYN PARK, MN	55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
5 825	Continued From pa	ige 3	5 825			
	When walking to he client into the table.	ing directed to her chair. er chair C2 pushed another Preventative measures t walk with C2 all the way to				
	8/9/20, C2 was directed to stay in her seat had an ATO (aggression toward others) on who was seated next to her.	ssion toward others) on C4				
	shoulder causing cl Preventative measu	d another client on the right lient to fall to the floor. ures included, shadow C2 veen her and other peers.				
	9/20/20, C2 charge into the wall with tw	d toward C4 and pushed him o hands.				
inter Du 2:0 sou an wo sta sta sta two PM fall	2:00 p.m. program sometimes C2 had and there was a lot would aggress aga stated for the most stated if C2 was ab her to sit down and stated other times of two handed pushed PM-B stated she w fallen as a result of	9/24/20, at approximately manager (PM)-B stated aggression when it was loud going on. PM-B stated C2 inst staff or other clients and part it was pretty mild. PM-B out to "charge" staff would tell usually that worked. The PM C2 would aggress and one or d or may charge at someone. as unaware if any clients had C2's aggression but stated any injuries to other clients.				
	disability profession "temporary interrup got aggressive. The themselves betwee directed her to sit ir	p.m. the qualified intellectual nal (QIDP) stated "C2 had a tion procedure" for when she e QIDP stated staff put en C2 and other clients and her chair. The QIDP stated if c chair staff would basically				

01430 B. WING 09	С
	30/2020
IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5624 73RD AVE NO	
BROOKLYN PARK, MN 55429	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGPREFIX(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
5 825   Continued From page 4   5 825	
On 9/25/20, at 1:44 p.m. the QIDP stated the incidents of aggression between C2 and other clients had not been reported to the SA. The QIDP stated a report was not required unless there was an injury as a result of an altercation. The QIDP stated if there was no injury, then no report was needed. A facility policy titled Vulnerable Adults Abuse Prevention Plan, Internal Reporting System undated, indicated verbal or physical aggression between clients does not constitute abuse unless the behavior causes serious harm.	

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	Сом	E SURVEY PLETED
		24G382	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SHINGLE	E CREEK OPTION				624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	ſS	W 0	000			
	conducted to invest The complaint was	20, an abbreviated survey was tigate complaint HG382004C. substantiated and deficiencies , W336, W149, W153					
		dition of Participation- health ces was found not to be in CFR 483.460.					
W 149	An full survey was of STAFF TREATMEN CFR(s): 483.420(d)		W 14	49			
	policies and proced	evelop and implement written lures that prohibit ect or abuse of the client.					
	Based on interview facility failed to deve prevention policy w immediately report	s not met as evidenced by: y and document review, the elop a facility abuse hich directed staff to client to client abuse for 1 of 3 ed who displayed physically rs towards others.					
	Findings include:						
	Prevention Plan, In undated, indicated	d Vulnerable Adults Abuse ternal Reporting System verbal or physical aggression es not constitute abuse unless s serious harm.					
		cident and Incident Reports 0 identified the following:					
	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		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.

PRINTED: 10/20/2020

		AND HUMAN SERVICES				FORM	10/20/2020 APPROVED 0938-0391
STATEMENT OF DEFICI AND PLAN OF CORREC	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G382	B. WING				C 30/2020
NAME OF PROVIDER	OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SHINGLE CREEK	OPTION				624 73RD AVE NO BROOKLYN PARK, MN 55429		
PREFIX (EAC	CH 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
-6/25/20 shoved measur when the -7/8/20, chair. A window chair. C from C2 others a affect. -7/9/20, and C2 and wal included were are -7/12/20 bathroo pushed included for anyc -7/13/20 C2 push Prevent eye on 0 in the ap -7/15/20 C5. Pre keep clo -7/18/20 walked	the client in es included ere is only of C2 had bee nother clien . C2 stood u 5 moved be 2. Preventa away from h C2 was sitt pushed C4 ked away. d, keep s cl ound. 0, C2 came m. Another the client. I d, try to re-d one who wal 0, C4 was w hed him with ative measu C2 and her partment. 0, C5 wande eventative m ose eye on w	ed at another client (C4) and to a cabinet. Preventative , keep a closer eye on C2 one staff in the apartment. en anxious and was sitting in a t (C5) was looking out the up and pushed C5 into an arm whind the chair to get away tive measures included, keep er when she is in an anxious ing in a chair, C4 walked by with one hand. C4 stumbled Preventative measures ose eye on C2 when peers out of her room to use the client walked by and C2 Preventative measures irect C2 while creating a shield	W	149			

		AND HUMAN SERVICES				FORM	10/20/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		24G382	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SHINGLE	E CREEK OPTION				624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 149	Continued From pa don't reach each ot -7/30/20, C2 was be When walking to he client into the table. included, staff must chair. -8/9/20, C2 was dire had an ATO (aggres who was seated ne -9/16/20, C2 pushe shoulder causing cl Preventative measu closer and get betw -9/20/20, C2 charge into the wall with tw During interview on 2:00 p.m. program sometimes C2 had and there was a lot would be aggressiv and stated for the n PM-B stated if C2 w would tell her to sit The PM stated othe aggressive and one may charge at som unaware if any clier C2's aggression bu any injuries to other	Ige 2 her in the apartment. eing directed to her chair. er chair C2 pushed another Preventative measures t walk with C2 all the way to ected to stay in her seat and ssion toward others) on C4 xt to her. d another client on the right lient to fall to the floor. ures included, shadow C2 veen her and other peers. ed toward C4 and pushed him to hands. 9/24/20, at approximately manager (PM)-B stated aggression when it was loud going on. PM-B stated C2 re against staff or other clients nost part it was pretty mild. vas about to "charge," staff down and usually that worked. er times C2 would be e or two handed pushed or eone. PM-B stated she was nts had fallen as a result of t stated there had not been r clients. p.m. the qualified intellectual hal (QIDP) stated "C2 had a	W 1	49	DEFICIENCY)		
	disability profession "temporary interrup						

If continuation sheet Page 3 of 15

STATEMENT OF DEFICIENCIES       (*1) PROVIDERSUPPLIER/CLIA       (x2) MULTIPLE CONSTRUCTION       (x3) DATE SURVEY         AND PLAN OF CORRECTION       24G382       b. WING       (x3) DATE SURVEY         24G382       b. WING       09/30/2020         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       C         SHINGLE CREEK OPTION       STREET ADDRESS, CITY, STATE, ZIP CODE       5624 73R0 XE NO         PREFIX       SUMMARY STATEMENT OF DEFICIENCIES       PROVIDER'S PLAN OF CORRECTION SHOULD BE       COMPLETION         (x4) ID       SUMMARY STATEMENT OF DEFICIENCIES       PROVIDER'S PLAN OF CORRECTION SHOULD BE       COMPLETION         (x4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER OR SUPPLIER'S PLAN OF CORRECTION SHOULD BE       COMPLETION         (x4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER OR SUPPLIER'S PLAN OF CORRECTION SHOULD BE       COMPLETION         (x4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX       TAG       CONSTRUCTION SHOULD BE         (x4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER OR CORRECTION SHOULD BE       COMPLETION         W 149       Continued From page 3       W 149       W 149       ID       Continued From page 3       W 149         Incidents of aggression betwee			AND HUMAN SERVICES			FORM	10/20/2020 APPROVED 0938-0391
24G382     B. WING     09/30/2020       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     STREET ADDRESS, CITY, STATE, ZIP CODE       SHINGLE CREEK OPTION     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COMPLETION DATE       W 149     Continued From page 3 themselves between C2 and other clients and directed her to sit in her chair. The QIDP stated if C2 did not sit in her chair. The QIDP stated if C2 did not sit in her chair staff would basically barricade her.     W 149     W 149       On 9/25/20, at 1:44 p.m. the QIDP stated the incidents of aggression between C2 and other clients had not been reported to the SA. The QIDP stated the agency was not required to report incidents of client to client altercations to the SA unless someone was injury. then no report was needed.     W 153       W 153     STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)     W 153	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ·	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
5624 73RD AVE NO BROOKLYN PARK, MN 55429       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COMULTION DATE       W 149     Continued From page 3 themselves between C2 and other clients and directed her to sit in her chair. The QIDP stated if C2 did not sit in her chair. The QIDP stated if C2 did not sit in her chair staff would basically barricade her.     W 149     W 149       On 9/25/20, at 1:44 p.m. the QIDP stated the incidents of aggression between C2 and other clients had not been reported to the SA. The QIDP stated the agency was not required to report incidents of client to client altercations to the SA unless someone was injured. The QIDP stated if there was no injury, then no report was needed.     W 153       W 153     STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)     W 153			24G382	B. WING	 		
SHINGLE CREEK OPTION       BROOKLYN PARK, MN 55429       (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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COMPLETION DATE       W 149     Continued From page 3 themselves between C2 and other clients and directed her to sit in her chair. The QIDP stated if C2 did not sit in her chair. The QIDP stated if C2 did not sit in her chair staff would basically barricade her.     W 149       On 9/25/20, at 1:44 p.m. the QIDP stated the incidents of aggression between C2 and other clients had not been reported to the SA. The QIDP stated the agency was not required to report incidents of client to client altercations to the SA unless someone was injured. The QIDP stated if there was no injury, then no report was needed.     W 153       W 153     STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)     W 153	NAME OF F	PROVIDER OR SUPPLIER					
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION DATE         W 149       Continued From page 3 themselves between C2 and other clients and directed her to sit in her chair. The QIDP stated if C2 did not sit in her chair staff would basically barricade her.       W 149       W 149         On 9/25/20, at 1:44 p.m. the QIDP stated the incidents of aggression between C2 and other clients had not been reported to the SA. The QIDP stated the agency was not required to report incidents of client to client altercations to the SA unless someone was injured. The QIDP stated if there was no injury, then no report was needed.       W 153       W 153         W 153       STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)       W 153       W 153	SHINGLE	E CREEK OPTION					
themselves between C2 and other clients and directed her to sit in her chair. The QIDP stated if C2 did not sit in her chair staff would basically barricade her.On 9/25/20, at 1:44 p.m. the QIDP stated the incidents of aggression between C2 and other clients had not been reported to the SA. The QIDP stated the agency was not required to report incidents of client to client altercations to the SA unless someone was injured. The QIDP stated if there was no injury, then no report was needed.W 153STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
<ul> <li>immediately to the administrator or to other officials in accordance with State law through established procedures.</li> <li>This STANDARD is not met as evidenced by: Based on interview and document review the agency failed to notify the state agency (SA) of client to to client abuse for 3 of 3 clients (C2,C4,C5) reviewed for abuse.</li> <li>Finding include:</li> <li>C2's Health Care Plan 2020, identified a history of aggressive behaviors. C2's Intensive Support Services Assessment (ISSA) dated September 2019 - September 2020, identified behaviors affecting her ability to self manage including a</li> </ul>		themselves betwee directed her to sit in C2 did not sit in her barricade her. On 9/25/20, at 1:44 incidents of aggress clients had not been QIDP stated the ag report incidents of of the SA unless some stated if there was needed. STAFF TREATMEN CFR(s): 483.420(d) The facility must en mistreatment, negle injuries of unknown immediately to the a officials in accordar established procedu This STANDARD is Based on interview agency failed to not client to to client ab (C2,C4,C5) reviewe Finding include: C2's Health Care P aggressive behavio Services Assessme 2019 - September 2	<ul> <li>an C2 and other clients and her chair. The QIDP stated if chair staff would basically</li> <li>b. p.m. the QIDP stated the sion between C2 and other in reported to the SA. The ency was not required to client to client altercations to eone was injured. The QIDP no injury, then no report was</li> <li>NT OF CLIENTS (2)</li> <li>asure that all allegations of ect or abuse, as well as a source, are reported administrator or to other noce with State law through ures.</li> <li>s not met as evidenced by: and document review the tify the state agency (SA) of use for 3 of 3 clients ed for abuse.</li> <li>lan 2020, identified a history of ors. C2's Intensive Support ent (ISSA) dated September 2020, identified behaviors</li> </ul>				

Facility ID: 01430

If continuation sheet Page 4 of 15

		AND HUMAN SERVICES				FORM	10/20/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G382	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
SHINGLE	CREEK OPTION				624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 153	Continued From pa books/magazines.	ge 4	W 1	53			
		cident and Incident Reports 0 identified the following:					
	shoved the client in measures included,	d at another client (C4) and to a cabinet. Preventative , keep a closer eye on C2 one staff in the apartment.					
	chair. Another Clier window. C2 stood u chair. C5 moved be from C2. Preventat	n anxious and was sitting in a nt (C5) was looking out the up and pushed C5 into an arm whind the chair to get away tive measures included, keep er when she is in an anxious					
	and C2 pushed C4 and walked away.	ng in a chair, C4 walked by with one hand. C4 stumbled Preventative measures ose eye on C2 when peers					
	bathroom. Another pushed the client.	but of her room to use the client walked by and C2 Preventative measures irect C2 while creating a shield ked by.					
	C2 pushed him with Preventative measu	alking around the apartment. In two hands into the counter. Ures included, keep a close distance from other individuals					
	C5. Preventative m	red near C2 and C2 pushed neasures included, continue to where res are in relation to C2.					

If continuation sheet Page 5 of 15

		AND HUMAN SERVICES				FORM	10/20/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G382	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SHINGLE	E CREEK OPTION				624 73RD AVE NO BROOKLYN PARK, MN 55429		
(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	(X5) COMPLETION DATE
W 153	Continued From pa	ge 5	W 1	53			
	walked in front of he hands in the chest. included, stay close	walking to her chair, C5 er. C2 pushed C5 with two Preventative measures to aggressing clients so they her in the apartment.					
	When walking to he client into the table.	ing directed to her chair. er chair C2 pushed another Preventative measures t walk with C2 all the way to					
		ected to stay in her seat and ssion toward others) on C4 xt to her.					
	shoulder causing cl Preventative measu	d another client on the right lient to fall to the floor. ures included, shadow C2 veen her and other peers.					
	9/20/20, C2 charged into the wall with two	d toward C4 and pushed him o hands.					
	2:00 p.m. program sometimes C2 had and there was a lot would aggress agai stated for the most stated if C2 was ab her to sit down and stated other times C two handed pushed PM-B stated she wa fallen as a result of	9/24/20, at approximately manager (PM)-B stated aggression when it was loud going on. PM-B stated C2 inst staff or other clients and part it was pretty mild. PM-B out to "charge" staff would tell usually that worked. The PM C2 would aggress and one or d or may charge at someone. as unaware if any clients had C2's aggression but stated any injuries to other clients.					

If continuation sheet Page 6 of 15

		AND HUMAN SERVICES				FORM	10/20/2020 APPROVED		
							0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			Сом	E SURVEY PLETED		
		24G382	B. WING				C 30/2020		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
SHINGLE	E CREEK OPTION				624 73RD AVE NO ROOKLYN PARK, MN 55429				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
W 153 W 318	On 9/24/20, at 2:51 disability profession "temporary interrup got aggressive. The themselves betwee directed her to sit in C2 did not sit in her barricade her. On 9/25/20, at 1:44 incidents of aggress clients had not beer QIDP stated a repo there was an injury The QIDP stated if report was needed. A facility policy titled Prevention Plan, Int undated, indicated	p.m. the qualified intellectual hal (QIDP) stated "C2 had a tion procedure" for when she e QIDP stated staff put en C2 and other clients and her chair. The QIDP stated if r chair staff would basically p.m. the QIDP stated the sion between C2 and other n reported to the SA. The ort was not required unless as a result of an altercation. there was no injury, then no d Vulnerable Adults Abuse ternal Reporting System verbal or physical aggression es not constitute abuse unless s serious harm.	W 1		DEFICIENCY)				
	The facility must en services requirement	nsure that specific health care nts are met.							
	Based on observat review, the Conditio 483.460, health car agency failed to ens and implementation	is not met as evidenced by: tion, interview and document on of Participation at 42 CFR re services was not met. The sure thorough assessment n of interventions to reduce is for 1 of 1 clients (C1)							

If continuation sheet Page 7 of 15

		AND HUMAN SERVICES				FORM	10/20/2020 APPROVED 0938-0391				
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED				
		24G382	B. WING				C 30/2020				
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE								
SHINGLE	CREEK OPTION				624 73RD AVE NO ROOKLYN PARK, MN 55429						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE				
W 318	Continued From pa	ge 7	W 3	18							
	Findings include:										
W 331	implement practices 1 of 1 clients (C1) r	ES	W 3	31							
	, j	ovide clients with nursing nce with their needs.									
	Based on observat review, the agency comprehensive ass develop and implem	s not met as evidenced by: tion, interview and document failed to complete a sessment of falls and failed to nent interventions to reduce lls for 1 of 1 clients (C1) ple falls.									
	Findings include:										
	(ISSA) dated 9/10/1 coordination along v placed him at risk if indicated C1 had a 8/21/19, at which tir recommended to co when walking long o The physical therap using a tub instead ISSA directed staff	ontrol speed and offer support distances or in the community. by assessment also indicated of shower for bathing. The									
		C1 experienced a total of 25									

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		AND HUMAN SERVICES				FORM	10/20/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G382	B. WING				30/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SHINGLE	E CREEK OPTION				624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	Continued From pa	ge 8	W 3	31			
	missed the chair an	ttempting to sit at the table, nd fell. Preventative measures 1 closely for imbalance.					
	and slipped to his b on the arm rest of t	tanding up from the commode oottom. C1 scraped his elbow he commode. Preventative , monitor C1's gait in early g commode.					
	heard a thump and bottom. Preventativ	d into his room for a nap. Staff found him on the floor on his re measures included, closely oing into his room alone.					
	started walking, los bottom. C1 hit his b neck on the wall. Pr	up from his chair abruptly, t his balance and fell on his back, shoulder blades and reventative measures included ely when moving in the					
	hammock and C1 k C1 to the ground ho Preventative measu	e attempting to put C1 in the ost his balance. Staff lowered olding his gait belt. ures included, consider two C1 into the hammock.					
		ashing and drying his hands Staff lowered him to the floor.					
	his bottom. Prevent	up from a chair and fell onto tative measures included, when standing up from chairs.					
	-8/5/20, Staff were t when he fell.	following C1 to the kitchen					

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		AND HUMAN SERVICES				FORM	10/20/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G382	B. WING				C 30/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SHINGL	E CREEK OPTION				624 73RD AVE NO ROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	-8/9/20, C1 was get and lost his balance second time when s up. -8/13/20, C1 fell att chair. Preventative use of black shoes -8/19/20, C1's motie entered his room at floor was wet so sta Preventative measu mat "or something" there was an inapp -8/20/20, C1 got up slipped off and he t his knees. Preventa monitor C1's gait w -8/20/20, C1 was w bed, slipped on the his knees. Preventa monitor C1 when w -8/21/20, C1 was at Preventative measu cleaned regularly to -8/22/20, Staff hear from C1's room. Sta of his bedroom. Sta fell three more time get their footing. C1 Preventative measu floor for urine and r	tting clothes out of his closet e and fell. C1 then fell a staff were trying to assist him empting to sit on a kitchen measures included, consider instead of brown shoes. on sensor sounded and staff nd found C1 on the floor. C1's aff assumed he slipped. ures included, C1 may need a to provide more grip when	W 3	31			

If continuation sheet Page 10 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/20/2020 APPROVED 0938-0391
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24G382	B. WING				C 30/2020
NAME OF PROVID	DER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SHINGLE CRE	EK OPTION				624 73RD AVE NO BROOKLYN PARK, MN 55429		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331 Conf Prev close 9/3/2 foun mea woke -9/4/ clien Prev close -9/8/ bath -9/9/ slipp -9/12 Prev bath -9/13 fell w unsu mea sturc -9/13 fell w	ely. 20, C1's motion d sitting on the sures included, e up on the ove /20, C1 was am nt and fell and a /entative measu ely when movin /20, C1 was wal room, tripped a /20, C1 was wal room, tripped a /20, C1 was in th bed and fell. 2/20, C1 fell cor /entative measu room for him. 3/20, C1 was se with the chair on ure what caused sures included, dily at all times. 3/20, C1 was br day by two staff t foot and confus 9/20, Staff obse s right ear. Staff	sensor sounded and he was floor in urine. Preventative closely monitor C1 when he might shift. bulating, bumped into another nd bumped his head. ures included, shadow C1 g around. lking with staff from the ind fell. he bathroom with staff, ming out of the shower. ures included, dry floor of eated at the dining table and nto his right side. Staff were d the fall. Preventative make sure he was seated	W 3	531	DEFICIENCY)		

		AND HUMAN SERVICES				FORM	10/20/2020 APPROVED 0938-0391			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
24G382		B. WING			C 09/30/2020					
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
SHINGLI	E CREEK OPTION		5624 73RD AVE NO BROOKLYN PARK, MN 55429							
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE			
W 331	<ul> <li>-9/22/20, C1 was in thump and found hi measures included, his room.</li> <li>Review of C1's Host dated 9/15/20 indicated 9/15/20 indicated 0/15/20 indicated falls in the last 24 indicated C1 had be and evaluation and with recommendate staff to monitor and times.</li> <li>During observation skills instructor (LSI bathroom. LSI-A left briefly, then returne C1 ambulated back was wearing a tower Wet foot prints were leading out into the C1 ambulated to the onto the back of hist During interview on member (FM)-A state and stated he/she f with him on that. FM belt they were using about the belt last y During interview on stated before C1 we unstable and his batter of the back of hist batter of the back of hist batter of the back of hist batter on the back of hist batter on the back of hist batter of the back of hist bac</li></ul>	a his room alone. Staff heard a im on the floor. Preventative , monitor C1 closely when in spital Discharge Summary, ated C1 had autism,was deaf, rienced an increased number 4 hours. The summary een admitted for observation was diagnosed with a stroke, on from physical therapy for assist with ambulation at all on 9/24/20, at 9:54 a.m. living I)-A escorted C1 to the ft C1 in the bathroom alone ed with a towel. At 10:11 a.m. to his room with LSI-A. C1 el and did not have shoes on. e noted on the bathroom floor common area. At 10:16 a.m. e kitchen while LSI-A held a shirt. 9/24/20, at 10:35 a.m. family ated C1 was very impulsive felt the agency was working M-A stated staff now had a gait g and stated they had talked	W 3	331						

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	RINTED: 10/20/2020 FORM APPROVED MB NO. 0938-0391									
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
24G382		B. WING	i		C 09/30/2020					
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
SHINGL	E CREEK OPTION		5624 73RD AVE NO BROOKLYN PARK, MN 55429							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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	(X5) COMPLETION DATE			
W 331	because he was so belt was being used the premises. LSI-A interventions were l staff to document p A review of the kios "When ambulatory possible obstacles balance and suppor 2017-2018. On 9/24/20, at 1:36 (PM)-A stated C1 w PM-A stated one m fallen and gone to t days later. PM-A state facility decided to d PM-A stated C1 had was checked on ev PM-A stated When 0 wherever he went. On 9/24/20, at 2:22 stated C1 had man hospitalization, C1 w therapy. RN-A state for C1 had been do stated she felt he ha mobility. RN-A verif comprehensively as she had not been a until a week prior to to the Incident/Accid did not read them a me," they go to the professional (QIDP	<ul> <li>a fast. LSI-A stated a transfer d only when C1 was outside A further stated fall located on the kiosk (used for progress notes).</li> <li>ak indicated, monitor for falling. monitor for steady gait and and in tricky terrain, provide rt." The tasks were dated</li> <li>b p.m. the program manager vas not stable and he "trips." forning he came in and C1 had the hospital and returned two ated after hospitalization, the io a one to one staff for C1. d a camera in his room and rery two hours while in bed. C1 was up staff followed him</li> <li>c p.m. registered nurse (RN)-A y falls recently and was 3/20. RN-A stated following the was assessed by physical ed the last facility assessment one in December of 2019 and ad a definite decrease in</li> </ul>	W 3	331						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/20/2020 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		24G382	B. WING			C 09/30/2020				
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
SHINGLE	CREEK OPTION		5624 73RD AVE NO BROOKLYN PARK, MN 55429							
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
W 331	Continued From pa there had been a la communication at the On 9/24/19, at 2:39 incident reports were reviewed them and The QIDP stated not comprehensive ass QIDP stated when 0 should have been us implemented becau trained how to use in During a telephone a.m. C1's clinic RN made the physician The clinic RN states from facilities when she could not find a indicating the agence falls. An agency policy re- requested but not re- NURSING SERVIC CFR(s): 483.460(c) Nursing services m certified as not need review of their healt quarterly or more fr client need.	ge 13 ck of staff and a lack of he agency. p.m. the QIDP stated the re filled out by staff and he discussed them with RN-A. o one had completed a essment of C1's falls. The C1 was awake a transfer belt used but had not been use staff had not been properly t. interview on 9/24/20, at 9:35 stated the agency had not aware C1 had so many falls. d they usually received notices clients were falling and stated iny notes in the clinic records cy had notified them of C1's lated to client falls was eceived. ES	W 3	331						
	facility's nurse failed	and document review the d to ensure 1 of 3 clients (C1) a quarter, (90 days apart) for								

		AND HUMAN SERVICES				FORM	10/20/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
24G382		B. WING			C 09/30/2020		
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SHINGLE	E CREEK OPTION				5624 73RD AVE NO BROOKLYN PARK, MN 55429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 336	Continued From pa changes in health c ensure a yearly phy physician for 1 of 3 Findings include: C1's Health Care P that included Autisn Hydrocephalus and Plan identified area hearing, vision, beh The care plan was (RN)-A January 202 and July of 2020 we portion of the Health physical exam was due August 2020. F record lacked evide completed by a phy Health Care Plan in assessment had be but did not address During interview on stated C1 was due	ige 14 care status. In addition failed to /sical was completed by the	W 3		DEFICIENCY)		
	on it, even though C for other appointme unsure if C1 had se year. In regard to the stated she had not	C1 had been out of the facility ents. RN-A stated she was een his physician since last he quarterly review, RN-A signed off on the completion views because she "just					

Facility ID: 01430

If continuation sheet Page 15 of 15



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed November 24, 2020

Administrator Shingle Creek Option 5624 73rd Ave No Brooklyn Park, MN 55429

Dear Administrator:

Event ID: VXJR11 - Notice of Termination due to Condition of Participation (CoP) not met

Dear Administrator:

On September 30, 2020, a complaint investigation survey was conducted at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. At the time of the investigation, the survey team noted one or more deficiencies and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities for Individuals with Intellectual Disabilities (ICFs/IID):

## W318 42 CFR 483.420 Health Care Services

As of November 24, 2020, the Condition of Participation has not been corrected. Therefore, we are recommending to the Minnesota Department of Human Services that your Medicaid agreement to provide services as an Intermediate Care Facility for Individuals with Intellectual Disabilities be terminated. The termination date will be December 29, 2020.

The Minnesota Department of Human Services will notify you of their decision regarding our termination recommendation and your appeal rights.

If you have any quetions on this matter, please contact me.

Any Johour

Amy Johnson, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Telephone: 651-201-4121



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email December 7, 2020

Administrator Shingle Creek Option 5624 73rd Ave No Brooklyn Park, MN 55429

RE: Event ID: VXJR12

Dear Administrator:

On November 24, 2020, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) 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. Based on the PCR complaint investigation, we have determined your facility does meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and standard deficiencies pursuant to the complaint investigation, on September 30, 2020. The Condition of Participation that was corrected is listed below.

W318 42 CFR § 483.420 Health Care Services

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

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

Sincerely,

Any Johoan

Amy Johnson, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Telephone: 651-201-4121 Fax: 651-201-9697

Enclosure

cc: Licensing and Certification File