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

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,

Amy Johnson

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

DEPARTMENT OF HEALTH

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,

Amy Johnson

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01430	A. BUILDING: _____ B. WING _____	C 09/30/2020

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 9/23/20 - 9/30/20, 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).	5 000		
5 825	MN Statute 626.557 Subd. 4. VA Reporting.	5 825		

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5 825	Continued From page 1 A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement 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. Finding include: 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 history of throwing bowels, plates, phones and books/magazines. A review of C2's Accident and Incident Reports dated 6/2020-9/2020 identified the following: 6/25/20, C1 charged at another client (C4) and	5 825		

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5 825	Continued From page 2 shoved the client into a cabinet. Preventative measures included, keep a closer eye on C2 when there is only one staff in the apartment. 7/8/20, C2 had been anxious and was sitting in a chair. Another Client (C5) was looking out the window. C2 stood up and pushed C5 into an arm chair. C5 moved behind the chair to get away from C2. Preventative measures included, keep others away from her when she is in an anxious affect. 7/9/20, C2 was sitting in a chair, C4 walked by and C2 pushed C4 with one hand. C4 stumbled and walked away. Preventative measures included, keep s close eye on C2 when peers were around. 7/12/20, C2 came out of her room to use the bathroom. Another client walked by and C2 pushed the client. Preventative measures included, try to re-direct C2 while creating a shield for anyone who walked by. 7/13/20, C4 was walking around the apartment. C2 pushed him with two hands into the counter. Preventative measures included, keep a close eye on C2 and her distance from other individuals in the apartment. 7/15/20, C5 wandered near C2 and C2 pushed C5. Preventative measures included, continue to keep close eye on where res are in relation to C2. 7/18/20, As C2 was walking to her chair, C5 walked in front of her. C2 pushed C5 with two hands in the chest. Preventative measures included, stay close to aggressing clients so they don't reach each other in the apartment.	5 825	5 825 The facility's Vulnerable Adults Abuse Prevention Plan will be updated to specify that all incidents of verbal or physical aggression between clients will be immediately reported to the QIDP, regardless of amount of harm caused. The policy will direct the QIDP to report all incidents of verbal or physical aggression to the state agency. All staff will receive a copy of the updated policy and retraining on the updated procedure by 11/12/20. New staff will receive a copy of the updated policy as part of their initial intake at Alternatives for People with Autism (Alternatives) and will be trained on the updated Vulnerable Adults Abuse Prevention Plan prior to working their first direct care shift. The updated Vulnerable Adults Abuse Prevention Plan will be reviewed on a quarterly basis by the QIDP and the Human Rights Committee, to ensure its continued efficacy. If failures in the reporting of verbal or physical aggression are found at that time, or any other time between scheduled reviews, the QIDP will be responsible for addressing these deficiencies with a revised Vulnerable Adults Abuse Prevention Plan within three days of the discovery of the deficiency.	11/14/2020

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5 825	Continued From page 3 7/30/20, C2 was being directed to her chair. When walking to her chair C2 pushed another client into the table. Preventative measures included, staff must walk with C2 all the way to chair. 8/9/20, C2 was directed to stay in her seat and had an ATO (aggression toward others) on C4 who was seated next to her. 9/16/20, C2 pushed another client on the right shoulder causing client to fall to the floor. Preventative measures included, shadow C2 closer and get between her and other peers. 9/20/20, C2 charged toward C4 and pushed him into the wall with two hands. During interview on 9/24/20, at approximately 2:00 p.m. program manager (PM)-B stated sometimes C2 had aggression when it was loud and there was a lot going on. PM-B stated C2 would aggress against staff or other clients and stated for the most part it was pretty mild. PM-B stated if C2 was about to "charge" staff would tell her to sit down and usually that worked. The PM stated other times C2 would aggress and one or two handed pushed or may charge at someone. PM-B stated she was unaware if any clients had fallen as a result of C2's aggression but stated there had not been any injuries to other clients. On 9/24/20, at 2:51 p.m. the qualified intellectual disability professional (QIDP) stated "C2 had a "temporary interruption procedure" for when she got aggressive. The QIDP stated staff put 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.	5 825		

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5 825	Continued From page 4 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.	5 825		

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W 000	INITIAL COMMENTS On 9/23/20 - 9/30/20, an abbreviated survey was conducted to investigate complaint HG382004C. The complaint was substantiated and deficiencies were cited at W331, W336, W149, W153 In addition, the Condition of Participation- health care services services was found not to be in compliance with 42 CFR 483.460. An full survey was conducted 9/29/20 - 9/30/20.	W 000	 received 11/4/20 approved 11/10/20 POC 11/4/20	
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to develop a facility abuse prevention policy which directed staff to immediately report client to client abuse for 1 of 3 clients (C2) reviewed who displayed physically aggressive behaviors towards others. Findings include: 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. A review of C2's Accident and Incident Reports dated 6/2020-9/2020 identified the following:	W 149	W149 The facility's Vulnerable Adults Abuse Prevention Plan will be updated to specify that all incidents of verbal or physical aggression between clients will be immediately reported to the QIDP, regardless of amount of harm caused. The policy will direct the QIDP to report all incidents of verbal or physical aggression to the state agency. All staff will receive a copy of the updated policy and retraining on the updated procedure by 11/12/20. New staff will receive a copy of the updated policy as part of their initial intake at Alternatives for People with Autism (Alternatives) and will be trained on the updated (continued over)	

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

Director 10/29/2020

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

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W 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. 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 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review the 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. Finding include: 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 history of throwing bowels, plates, phones and	W 153	W153 The facility's Vulnerable Adults Abuse Prevention Plan will be updated to direct the QIDP to report all incidents of verbal or physical aggression to the state agency, regardless of the amount of harm caused. All staff will receive a copy of the updated policy and retraining on the updated procedure by 11/12/20. New staff will receive a copy of the updated policy as part of their initial intake at Alternatives and will be trained on the updated Vulnerable Adults Abuse Prevention Plan prior to working their first direct care shift. (continued over)	

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W 153	Continued From page 4 books/magazines. A review of C2's Accident and Incident Reports dated 6/2020-9/2020 identified the following: 6/25/20, C1 charged at another client (C4) and shoved the client into a cabinet. Preventative measures included, keep a closer eye on C2 when there is only one staff in the apartment. 7/8/20, C2 had been anxious and was sitting in a chair. Another Client (C5) was looking out the window. C2 stood up and pushed C5 into an arm chair. C5 moved behind the chair to get away from C2. Preventative measures included, keep others away from her when she is in an anxious affect. 7/9/20, C2 was sitting in a chair, C4 walked by and C2 pushed C4 with one hand. C4 stumbled and walked away. Preventative measures included, keep s close eye on C2 when peers were around. 7/12/20, C2 came out of her room to use the bathroom. Another client walked by and C2 pushed the client. Preventative measures included, try to re-direct C2 while creating a shield for anyone who walked by. 7/13/20, C4 was walking around the apartment. C2 pushed him with two hands into the counter. Preventative measures included, keep a close eye on C2 and her distance from other individuals in the apartment. 7/15/20, C5 wandered near C2 and C2 pushed C5. Preventative measures included, continue to keep close eye on where res are in relation to C2.	W 153	(W153 cont.) The updated Vulnerable Adults Abuse Prevention Plan will be reviewed on a quarterly basis by the QIDP and the Human Rights Committee, to ensure its continued efficacy. If failures in the reporting of verbal or physical aggression are found at that time, or any other time between scheduled reviews, the QIDP will be responsible for addressing these deficiencies with a revised Vulnerable Adults Abuse Prevention Plan within three days of the discovery of the deficiency.	11/14/2020

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W 153	Continued From page 5 7/18/20, As C2 was walking to her chair, C5 walked in front of her. C2 pushed C5 with two hands in the chest. Preventative measures included, stay close to aggressing clients so they don't reach each other in the apartment. 7/30/20, C2 was being directed to her chair. When walking to her chair C2 pushed another client into the table. Preventative measures included, staff must walk with C2 all the way to chair. 8/9/20, C2 was directed to stay in her seat and had an ATO (aggression toward others) on C4 who was seated next to her. 9/16/20, C2 pushed another client on the right shoulder causing client to fall to the floor. Preventative measures included, shadow C2 closer and get between her and other peers. 9/20/20, C2 charged toward C4 and pushed him into the wall with two hands. During interview on 9/24/20, at approximately 2:00 p.m. program manager (PM)-B stated sometimes C2 had aggression when it was loud and there was a lot going on. PM-B stated C2 would aggress against staff or other clients and stated for the most part it was pretty mild. PM-B stated if C2 was about to "charge" staff would tell her to sit down and usually that worked. The PM stated other times C2 would aggress and one or two handed pushed or may charge at someone. PM-B stated she was unaware if any clients had fallen as a result of C2's aggression but stated there had not been any injuries to other clients.	W 153		

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W 153	Continued From page 6 On 9/24/20, at 2:51 p.m. the qualified intellectual disability professional (QIDP) stated "C2 had a "temporary interruption procedure" for when she got aggressive. The QIDP stated staff put 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 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.	W 153	W318 Alternatives will complete a comprehensive assessment of falls for all residents for whom falling is a known risk by 11/12/20, or within ten calendar days of a newly emerging falling risk, whether permanent or temporary. The comprehensive assessments will be completed by the RN. Whenever the findings of an assessment suggest the implementation of an intervention, that intervention established at that time and all direct-care staff who work with the affected client will be trained in the new intervention prior to working with 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 efficacy of the interventions will be assessed on a quarterly basis or following significant changes in the mobility of a client. If at that time the interventions are judged to be insufficient to reduce the risk of falling, another assessment will be conducted within two weeks of that judgement and modified, or new interventions established.	11/14/2020
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the Condition of Participation at 42 CFR 483.460, health care services was not met. The agency failed to ensure thorough assessment and implementation of interventions to reduce the likelihood of falls for 1 of 1 clients (C1) reviewed for Falls.	W 318		

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W 318	Continued From page 7 Findings include: See W331: The facility failed to assess and implement practices to reduce the risk for falls for 1 of 1 clients (C1) reviewed.	W 318		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the agency failed to complete a comprehensive assessment of falls and failed to develop and implement interventions to reduce the likelihood for falls for 1 of 1 clients (C1) reviewed with multiple falls. Findings include: C1's Intensive Support Services Assessment (ISSA) dated 9/10/19, indicated poor balance and coordination along with osteoporosis which placed him at risk if he were to fall. The ISSA indicated C1 had a physical therapy assessment 8/21/19, at which time a gait belt was recommended to control speed and offer support when walking long distances or in the community. The physical therapy assessment also indicated using a tub instead of shower for bathing. The ISSA directed staff to monitor for falls. C1's Accident and Incident Reports dated 6/22/20 - 9/20/20, identified C1 experienced a total of 25 falls:	W 331	W331 Alternatives will complete a comprehensive assessment of falls for all residents for whom falling is a known risk by 11/12/20, or within ten calendar days of a newly emerging falling risk, whether permanent or temporary. The comprehensive assessments will be completed by the RN. Whenever the findings of an assessment suggest the implementation of an intervention, that intervention established at that time and all direct-care staff who work with the affected client will be trained in the new intervention prior to working with 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. (continued over)	

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W 331	Continued From page 8 -6/22/20, C1 was attempting to sit at the table, missed the chair and fell. Preventative measures included, monitor C1 closely for imbalance. -6/30/20, C1 was standing up from the commode and slipped to his bottom. C1 scraped his elbow on the arm rest of the commode. Preventative measures included, monitor C1's gait in early morning when using commode. -7/10/20, C1 walked into his room for a nap. Staff heard a thump and found him on the floor on his bottom. Preventative measures included, closely monitor C1 when going into his room alone. -7/12/20, C1 stood up from his chair abruptly, started walking, lost his balance and fell on his bottom. C1 hit his back, shoulder blades and neck on the wall. Preventative measures included shadowing C1 closely when moving in the apartment. -7/17/20, Staff were attempting to put C1 in the hammock and C1 lost his balance. Staff lowered C1 to the ground holding his gait belt. Preventative measures included, consider two staff when putting C1 into the hammock. -7/21/20, C1 was washing and drying his hands and started to fall. Staff lowered him to the floor. -7/30/20, C1 stood up from a chair and fell onto his bottom. Preventative measures included, shadow C1 closely when standing up from chairs. -8/5/20, Staff were following C1 to the kitchen when he fell.	W 331	(W331 cont.) The efficacy of the interventions will be assessed on a quarterly basis or following significant changes in the mobility/stability of a client. If at that time the interventions are judged to be insufficient to reduce the risk of falling, another assessment will be conducted within two weeks of that judgement and modified, or new interventions established.	11/14/2020

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W 331	Continued From page 9 -8/9/20, C1 was getting clothes out of his closet and lost his balance and fell. C1 then fell a second time when staff were trying to assist him up. -8/13/20, C1 fell attempting to sit on a kitchen chair. Preventative measures included, consider use of black shoes instead of brown shoes. -8/19/20, C1's motion sensor sounded and staff entered his room and found C1 on the floor. C1's floor was wet so staff assumed he slipped. Preventative measures included, C1 may need a mat "or something" to provide more grip when there was an inappropriate urination. -8/20/20, C1 got up from a chair, C1's shoe slipped off and he tripped forward and landed on his knees. Preventative measures included, monitor C1's gait when he got up quickly. -8/20/20, C1 was walking in his room toward his bed, slipped on the tile floor and fell forward onto his knees. Preventative measures included monitor C1 when walking on slippery flooring. -8/21/20, C1 was alone in his room when he fell. Preventative measures included, floor would be cleaned regularly to avoid slippery surface. -8/22/20, Staff heard loud vocalizations coming from C1's room. Staff found C1 sitting on the floor of his bedroom. Staff tried to assist him up and he fell three more times due to staff not being able to get their footing. C1's floor was wet from urine. Preventative measures included, frequently check floor for urine and monitor when awake in room. -8/29/20, C1 got up and ran to bathroom and fell.	W 331		

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W 331	Continued From page 10 Preventative measures included, monitor C1 closely. 9/3/20, C1's motion sensor sounded and he was found sitting on the floor in urine. Preventative measures included, closely monitor C1 when he woke up on the overnight shift. -9/4/20, C1 was ambulating, bumped into another client and fell and and bumped his head. Preventative measures included, shadow C1 closely when moving around. -9/8/20, C1 was walking with staff from the bathroom, tripped and fell. -9/9/20, C1 was in the bathroom with staff, slipped and fell. -9/12/20, C1 fell coming out of the shower. Preventative measures included, dry floor of bathroom for him. -9/13/20, C1 was seated at the dining table and fell with the chair onto his right side. Staff were unsure what caused the fall. Preventative measures included, make sure he was seated sturdily at all times. -9/13/20, C1 was brought to the hospital on Sunday by two staff after staff noticed a swollen right foot and confusion during the morning. -9/19/20, Staff observed heavy redness around C1's right ear. Staff suspected he had fallen and hit his head on an object. Preventative measures included, be sure to check for injury thoroughly, several times per day.	W 331		

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W 331	Continued From page 11 -9/22/20, C1 was in his room alone. Staff heard a thump and found him on the floor. Preventative measures included, monitor C1 closely when in his room. Review of C1's Hospital Discharge Summary, dated 9/15/20 indicated C1 had autism,was deaf, blind and had experienced an increased number of falls in the last 24 hours. The summary indicated C1 had been admitted for observation and evaluation and was diagnosed with a stroke, with recommendation from physical therapy for staff to monitor and assist with ambulation at all times. During observation on 9/24/20, at 9:54 a.m. living skills instructor (LSI)-A escorted C1 to the bathroom. LSI-A left C1 in the bathroom alone briefly, then returned with a towel. At 10:11 a.m. C1 ambulated back to his room with LSI-A. C1 was wearing a towel and did not have shoes on. Wet foot prints were noted on the bathroom floor leading out into the common area. At 10:16 a.m. C1 ambulated to the kitchen while LSI-A held onto the back of his shirt. During interview on 9/24/20, at 10:35 a.m. family member (FM)-A stated C1 was very impulsive and stated he/she felt the agency was working with him on that. FM-A stated staff now had a gait belt they were using and stated they had talked about the belt last year. During interview on 9/24/20, at 1:32 p.m. LSI-A stated before C1 went to the hospital he was unstable and his balance was not good. LSI-A stated staff guided C1 whenever he went to the bathroom. In regard to fall interventions, LSI-A stated it was hard to have C1 walk with staff	W 331		

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W 331	Continued From page 12 because he was so fast. LSI-A stated a transfer belt was being used only when C1 was outside the premises. LSI-A further stated fall interventions were located on the kiosk (used for staff to document progress notes). A review of the kiosk indicated, monitor for falling. "When ambulatory monitor for steady gait and possible obstacles and in tricky terrain, provide balance and support." The tasks were dated 2017-2018. On 9/24/20, at 1:36 p.m. the program manager (PM)-A stated C1 was not stable and he "trips." PM-A stated one morning he came in and C1 had fallen and gone to the hospital and returned two days later. PM-A stated after hospitalization, the facility decided to do a one to one staff for C1. PM-A stated C1 had a camera in his room and was checked on every two hours while in bed. PM-A stated when C1 was up staff followed him wherever he went. On 9/24/20, at 2:22 p.m. registered nurse (RN)-A stated C1 had many falls recently and was hospitalized on 9/13/20. RN-A stated following the hospitalization, C1 was assessed by physical therapy. RN-A stated the last facility assessment for C1 had been done in December of 2019 and stated she felt he had a definite decrease in mobility. RN-A verified she had not comprehensively assessed C1's falls and stated she had not been aware C1 had so many falls until a week prior to his hospitalization. In regard to the Incident/Accident forms, RN-A stated she did not read them and stated "these don't go to me," they go to the qualified intellectual disability professional (QIDP). RN-A stated she felt C1 needed a one to one staff and stated she felt	W 331		

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W 331	Continued From page 13 there had been a lack of staff and a lack of communication at the agency. On 9/24/19, at 2:39 p.m. the QIDP stated the incident reports were filled out by staff and he reviewed them and discussed them with RN-A. The QIDP stated no one had completed a comprehensive assessment of C1's falls. The QIDP stated when C1 was awake a transfer belt should have been used but had not been implemented because staff had not been properly trained how to use it. During a telephone interview on 9/24/20, at 9:35 a.m. C1's clinic RN stated the agency had not made the physician aware C1 had so many falls. The clinic RN stated they usually received notices from facilities when clients were falling and stated she could not find any notes in the clinic records indicating the agency had notified them of C1's falls. An agency policy related to client falls was requested but not received.	W 331		
W 336	NURSING SERVICES CFR(s): 483.460(c)(3)(iii) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and document review the facility's nurse failed to ensure 1 of 3 clients (C1) was reviewed every quarter, (90 days apart) for	W 336		

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W 336	Continued From page 14 changes in health care status. In addition failed to ensure a yearly physical was completed by the physician for 1 of 3 clients (C1). Findings include: 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 assessment had been completed August 2019, but did not address C1's falls since 2019. During interview on 9/29/20, at 2:23 p.m. RN-A stated C1 was due for his annual physical but because of COVID-19 they agency had held off on it, even though C1 had been out of the facility for other appointments. RN-A stated she was unsure if C1 had seen his physician since last year. In regard to the quarterly review, RN-A stated she had not signed off on the completion of C1's quarterly reviews because she "just knows" what's going on.	W 336	W336 The RN will conduct quarterly reviews of client health status and report the findings of those reviews to the QIDP upon completion. The QIDP will be responsible for ensuring the reviews are completed on a quarterly basis. The initial quarterly health status reviews will be completed by 11/12/20 and every 90 days thereafter.	11/12/20

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 9/23/20 - 9/30/20, 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).	5 000		
5 825	MN Statute 626.557 Subd. 4. VA Reporting.	5 825		

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5 825	Continued From page 1	5 825		

A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision.

This MN Requirement 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.

Finding include:

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 history of throwing bowels, plates, phones and books/magazines.

A review of C2's Accident and Incident Reports dated 6/2020-9/2020 identified the following:

6/25/20, C1 charged at another client (C4) and

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5 825	Continued From page 2	5 825		

shoved the client into a cabinet. Preventative measures included, keep a closer eye on C2 when there is only one staff in the apartment.

7/8/20, C2 had been anxious and was sitting in a chair. Another Client (C5) was looking out the window. C2 stood up and pushed C5 into an arm chair. C5 moved behind the chair to get away from C2. Preventative measures included, keep others away from her when she is in an anxious affect.

7/9/20, C2 was sitting in a chair, C4 walked by and C2 pushed C4 with one hand. C4 stumbled and walked away. Preventative measures included, keep s close eye on C2 when peers were around.

7/12/20, C2 came out of her room to use the bathroom. Another client walked by and C2 pushed the client. Preventative measures included, try to re-direct C2 while creating a shield for anyone who walked by.

7/13/20, C4 was walking around the apartment. C2 pushed him with two hands into the counter. Preventative measures included, keep a close eye on C2 and her distance from other individuals in the apartment.

7/15/20, C5 wandered near C2 and C2 pushed C5. Preventative measures included, continue to keep close eye on where res are in relation to C2.

7/18/20, As C2 was walking to her chair, C5 walked in front of her. C2 pushed C5 with two hands in the chest. Preventative measures included, stay close to aggressing clients so they don't reach each other in the apartment.

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	01430	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHINGLE CREEK OPTION	5624 73RD AVE NO BROOKLYN PARK, MN 55429

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5 825	Continued From page 3 7/30/20, C2 was being directed to her chair. When walking to her chair C2 pushed another client into the table. Preventative measures included, staff must walk with C2 all the way to chair. 8/9/20, C2 was directed to stay in her seat and had an ATO (aggression toward others) on C4 who was seated next to her. 9/16/20, C2 pushed another client on the right shoulder causing client to fall to the floor. Preventative measures included, shadow C2 closer and get between her and other peers. 9/20/20, C2 charged toward C4 and pushed him into the wall with two hands. During interview on 9/24/20, at approximately 2:00 p.m. program manager (PM)-B stated sometimes C2 had aggression when it was loud and there was a lot going on. PM-B stated C2 would aggress against staff or other clients and stated for the most part it was pretty mild. PM-B stated if C2 was about to "charge" staff would tell her to sit down and usually that worked. The PM stated other times C2 would aggress and one or two handed pushed or may charge at someone. PM-B stated she was unaware if any clients had fallen as a result of C2's aggression but stated there had not been any injuries to other clients. On 9/24/20, at 2:51 p.m. the qualified intellectual disability professional (QIDP) stated "C2 had a "temporary interruption procedure" for when she got aggressive. The QIDP stated staff put 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.	5 825		

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5 825	Continued From page 4 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.	5 825		

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W 000	INITIAL COMMENTS On 9/23/20 - 9/30/20, an abbreviated survey was conducted to investigate complaint HG382004C. The complaint was substantiated and deficiencies were cited at W331, W336, W149, W153 In addition, the Condition of Participation- health care services services was found not to be in compliance with 42 CFR 483.460. An full survey was conducted 9/29/20 - 9/30/20.	W 000		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to develop a facility abuse prevention policy which directed staff to immediately report client to client abuse for 1 of 3 clients (C2) reviewed who displayed physically aggressive behaviors towards others. Findings include: 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. A review of C2's Accident and Incident Reports dated 6/2020-9/2020 identified the following:	W 149		

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

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-6/25/20, C1 charged at another client (C4) and shoved the client into a cabinet. Preventative measures included, keep a closer eye on C2 when there is only one staff in the apartment.

-7/8/20, C2 had been anxious and was sitting in a chair. Another client (C5) was looking out the window. C2 stood up and pushed C5 into an arm chair. C5 moved behind the chair to get away from C2. Preventative measures included, keep others away from her when she is in an anxious affect.

-7/9/20, C2 was sitting in a chair, C4 walked by and C2 pushed C4 with one hand. C4 stumbled and walked away. Preventative measures included, keep s close eye on C2 when peers were around.

-7/12/20, C2 came out of her room to use the bathroom. Another client walked by and C2 pushed the client. Preventative measures included, try to re-direct C2 while creating a shield for anyone who walked by.

-7/13/20, C4 was walking around the apartment. C2 pushed him with two hands into the counter. Preventative measures included, keep a close eye on C2 and her distance from other individuals in the apartment.

-7/15/20, C5 wandered near C2 and C2 pushed C5. Preventative measures included, continue to keep close eye on where res are in relation to C2.

-7/18/20, As C2 was walking to her chair, C5 walked in front of her. C2 pushed C5 with two hands in the chest. Preventative measures included, stay close to aggressing clients so they

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W 149	Continued From page 2	W 149		

don't reach each other in the apartment.

-7/30/20, C2 was being directed to her chair. When walking to her chair C2 pushed another client into the table. Preventative measures included, staff must walk with C2 all the way to chair.

-8/9/20, C2 was directed to stay in her seat and had an ATO (aggression toward others) on C4 who was seated next to her.

-9/16/20, C2 pushed another client on the right shoulder causing client to fall to the floor. Preventative measures included, shadow C2 closer and get between her and other peers.

-9/20/20, C2 charged toward C4 and pushed him into the wall with two hands.

During interview on 9/24/20, at approximately 2:00 p.m. program manager (PM)-B stated sometimes C2 had aggression when it was loud and there was a lot going on. PM-B stated C2 would be aggressive against staff or other clients and stated for the most part it was pretty mild. PM-B stated if C2 was about to "charge," staff would tell her to sit down and usually that worked. The PM stated other times C2 would be aggressive and one or two handed pushed or may charge at someone. PM-B stated she was unaware if any clients had fallen as a result of C2's aggression but stated there had not been any injuries to other clients.

On 9/24/20, at 2:51 p.m. the qualified intellectual disability professional (QIDP) stated "C2 had a "temporary interruption procedure" for when she got aggressive. The QIDP stated staff put

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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. 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 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review the 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. Finding include: 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 history of throwing bowels, plates, phones and	W 153		

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W 153	Continued From page 4 books/magazines. A review of C2's Accident and Incident Reports dated 6/2020-9/2020 identified the following: 6/25/20, C1 charged at another client (C4) and shoved the client into a cabinet. Preventative measures included, keep a closer eye on C2 when there is only one staff in the apartment. 7/8/20, C2 had been anxious and was sitting in a chair. Another Client (C5) was looking out the window. C2 stood up and pushed C5 into an arm chair. C5 moved behind the chair to get away from C2. Preventative measures included, keep others away from her when she is in an anxious affect. 7/9/20, C2 was sitting in a chair, C4 walked by and C2 pushed C4 with one hand. C4 stumbled and walked away. Preventative measures included, keep s close eye on C2 when peers were around. 7/12/20, C2 came out of her room to use the bathroom. Another client walked by and C2 pushed the client. Preventative measures included, try to re-direct C2 while creating a shield for anyone who walked by. 7/13/20, C4 was walking around the apartment. C2 pushed him with two hands into the counter. Preventative measures included, keep a close eye on C2 and her distance from other individuals in the apartment. 7/15/20, C5 wandered near C2 and C2 pushed C5. Preventative measures included, continue to keep close eye on where res are in relation to C2.	W 153		

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W 153	Continued From page 5 7/18/20, As C2 was walking to her chair, C5 walked in front of her. C2 pushed C5 with two hands in the chest. Preventative measures included, stay close to aggressing clients so they don't reach each other in the apartment. 7/30/20, C2 was being directed to her chair. When walking to her chair C2 pushed another client into the table. Preventative measures included, staff must walk with C2 all the way to chair. 8/9/20, C2 was directed to stay in her seat and had an ATO (aggression toward others) on C4 who was seated next to her. 9/16/20, C2 pushed another client on the right shoulder causing client to fall to the floor. Preventative measures included, shadow C2 closer and get between her and other peers. 9/20/20, C2 charged toward C4 and pushed him into the wall with two hands. During interview on 9/24/20, at approximately 2:00 p.m. program manager (PM)-B stated sometimes C2 had aggression when it was loud and there was a lot going on. PM-B stated C2 would aggress against staff or other clients and stated for the most part it was pretty mild. PM-B stated if C2 was about to "charge" staff would tell her to sit down and usually that worked. The PM stated other times C2 would aggress and one or two handed pushed or may charge at someone. PM-B stated she was unaware if any clients had fallen as a result of C2's aggression but stated there had not been any injuries to other clients.	W 153		

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W 153	Continued From page 6 On 9/24/20, at 2:51 p.m. the qualified intellectual disability professional (QIDP) stated "C2 had a "temporary interruption procedure" for when she got aggressive. The QIDP stated staff put 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 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.	W 153		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the Condition of Participation at 42 CFR 483.460, health care services was not met. The agency failed to ensure thorough assessment and implementation of interventions to reduce the likelihood of falls for 1 of 1 clients (C1) reviewed for Falls.	W 318		

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W 318	Continued From page 7 Findings include: See W331: The facility failed to assess and implement practices to reduce the risk for falls for 1 of 1 clients (C1) reviewed.	W 318		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the agency failed to complete a comprehensive assessment of falls and failed to develop and implement interventions to reduce the likelihood for falls for 1 of 1 clients (C1) reviewed with multiple falls. Findings include: C1's Intensive Support Services Assessment (ISSA) dated 9/10/19, indicated poor balance and coordination along with osteoporosis which placed him at risk if he were to fall. The ISSA indicated C1 had a physical therapy assessment 8/21/19, at which time a gait belt was recommended to control speed and offer support when walking long distances or in the community. The physical therapy assessment also indicated using a tub instead of shower for bathing. The ISSA directed staff to monitor for falls. C1's Accident and Incident Reports dated 6/22/20 - 9/20/20, identified C1 experienced a total of 25 falls:	W 331		

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W 331	Continued From page 8 -6/22/20, C1 was attempting to sit at the table, missed the chair and fell. Preventative measures included, monitor C1 closely for imbalance. -6/30/20, C1 was standing up from the commode and slipped to his bottom. C1 scraped his elbow on the arm rest of the commode. Preventative measures included, monitor C1's gait in early morning when using commode. -7/10/20, C1 walked into his room for a nap. Staff heard a thump and found him on the floor on his bottom. Preventative measures included, closely monitor C1 when going into his room alone. -7/12/20, C1 stood up from his chair abruptly, started walking, lost his balance and fell on his bottom. C1 hit his back, shoulder blades and neck on the wall. Preventative measures included shadowing C1 closely when moving in the apartment. -7/17/20, Staff were attempting to put C1 in the hammock and C1 lost his balance. Staff lowered C1 to the ground holding his gait belt. Preventative measures included, consider two staff when putting C1 into the hammock. -7/21/20, C1 was washing and drying his hands and started to fall. Staff lowered him to the floor. -7/30/20, C1 stood up from a chair and fell onto his bottom. Preventative measures included, shadow C1 closely when standing up from chairs. -8/5/20, Staff were following C1 to the kitchen when he fell.	W 331		

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-8/9/20, C1 was getting clothes out of his closet and lost his balance and fell. C1 then fell a second time when staff were trying to assist him up.

-8/13/20, C1 fell attempting to sit on a kitchen chair. Preventative measures included, consider use of black shoes instead of brown shoes.

-8/19/20, C1's motion sensor sounded and staff entered his room and found C1 on the floor. C1's floor was wet so staff assumed he slipped. Preventative measures included, C1 may need a mat "or something" to provide more grip when there was an inappropriate urination.

-8/20/20, C1 got up from a chair, C1's shoe slipped off and he tripped forward and landed on his knees. Preventative measures included, monitor C1's gait when he got up quickly.

-8/20/20, C1 was walking in his room toward his bed, slipped on the tile floor and fell forward onto his knees. Preventative measures included monitor C1 when walking on slippery flooring.

-8/21/20, C1 was alone in his room when he fell. Preventative measures included, floor would be cleaned regularly to avoid slippery surface.

-8/22/20, Staff heard loud vocalizations coming from C1's room. Staff found C1 sitting on the floor of his bedroom. Staff tried to assist him up and he fell three more times due to staff not being able to get their footing. C1's floor was wet from urine. Preventative measures included, frequently check floor for urine and monitor when awake in room.

-8/29/20, C1 got up and ran to bathroom and fell.

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W 331	Continued From page 10	W 331		

Preventative measures included, monitor C1 closely.

9/3/20, C1's motion sensor sounded and he was found sitting on the floor in urine. Preventative measures included, closely monitor C1 when he woke up on the overnight shift.

-9/4/20, C1 was ambulating, bumped into another client and fell and and bumped his head. Preventative measures included, shadow C1 closely when moving around.

-9/8/20, C1 was walking with staff from the bathroom, tripped and fell.

-9/9/20, C1 was in the bathroom with staff, slipped and fell.

-9/12/20, C1 fell coming out of the shower. Preventative measures included, dry floor of bathroom for him.

-9/13/20, C1 was seated at the dining table and fell with the chair onto his right side. Staff were unsure what caused the fall. Preventative measures included, make sure he was seated sturdily at all times.

-9/13/20, C1 was brought to the hospital on Sunday by two staff after staff noticed a swollen right foot and confusion during the morning.

-9/19/20, Staff observed heavy redness around C1's right ear. Staff suspected he had fallen and hit his head on an object. Preventative measures included, be sure to check for injury thoroughly, several times per day.

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W 331	Continued From page 11	W 331		

-9/22/20, C1 was in his room alone. Staff heard a thump and found him on the floor. Preventative measures included, monitor C1 closely when in his room.

Review of C1's Hospital Discharge Summary, dated 9/15/20 indicated C1 had autism,was deaf, blind and had experienced an increased number of falls in the last 24 hours. The summary indicated C1 had been admitted for observation and evaluation and was diagnosed with a stroke, with recommendation from physical therapy for staff to monitor and assist with ambulation at all times.

During observation on 9/24/20, at 9:54 a.m. living skills instructor (LSI)-A escorted C1 to the bathroom. LSI-A left C1 in the bathroom alone briefly, then returned with a towel. At 10:11 a.m. C1 ambulated back to his room with LSI-A. C1 was wearing a towel and did not have shoes on. Wet foot prints were noted on the bathroom floor leading out into the common area. At 10:16 a.m. C1 ambulated to the kitchen while LSI-A held onto the back of his shirt.

During interview on 9/24/20, at 10:35 a.m. family member (FM)-A stated C1 was very impulsive and stated he/she felt the agency was working with him on that. FM-A stated staff now had a gait belt they were using and stated they had talked about the belt last year.

During interview on 9/24/20, at 1:32 p.m. LSI-A stated before C1 went to the hospital he was unstable and his balance was not good. LSI-A stated staff guided C1 whenever he went to the bathroom. In regard to fall interventions, LSI-A stated it was hard to have C1 walk with staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G382	A. BUILDING _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHINGLE 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 12	W 331		

because he was so fast. LSI-A stated a transfer belt was being used only when C1 was outside the premises. LSI-A further stated fall interventions were located on the kiosk (used for staff to document progress notes).

A review of the kiosk indicated, monitor for falling. "When ambulatory monitor for steady gait and possible obstacles and in tricky terrain, provide balance and support." The tasks were dated 2017-2018.

On 9/24/20, at 1:36 p.m. the program manager (PM)-A stated C1 was not stable and he "trips." PM-A stated one morning he came in and C1 had fallen and gone to the hospital and returned two days later. PM-A stated after hospitalization, the facility decided to do a one to one staff for C1. PM-A stated C1 had a camera in his room and was checked on every two hours while in bed. PM-A stated when C1 was up staff followed him wherever he went.

On 9/24/20, at 2:22 p.m. registered nurse (RN)-A stated C1 had many falls recently and was hospitalized on 9/13/20. RN-A stated following the hospitalization, C1 was assessed by physical therapy. RN-A stated the last facility assessment for C1 had been done in December of 2019 and stated she felt he had a definite decrease in mobility. RN-A verified she had not comprehensively assessed C1's falls and stated she had not been aware C1 had so many falls until a week prior to his hospitalization. In regard to the Incident/Accident forms, RN-A stated she did not read them and stated "these don't go to me," they go to the qualified intellectual disability professional (QIDP). RN-A stated she felt C1 needed a one to one staff and stated she felt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G382	A. BUILDING _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHINGLE CREEK OPTION	**5624 73RD AVE NO BROOKLYN PARK, MN 55429**

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W 331	Continued From page 13 there had been a lack of staff and a lack of communication at the agency. On 9/24/19, at 2:39 p.m. the QIDP stated the incident reports were filled out by staff and he reviewed them and discussed them with RN-A. The QIDP stated no one had completed a comprehensive assessment of C1's falls. The QIDP stated when C1 was awake a transfer belt should have been used but had not been implemented because staff had not been properly trained how to use it. During a telephone interview on 9/24/20, at 9:35 a.m. C1's clinic RN stated the agency had not made the physician aware C1 had so many falls. The clinic RN stated they usually received notices from facilities when clients were falling and stated she could not find any notes in the clinic records indicating the agency had notified them of C1's falls. An agency policy related to client falls was requested but not received.	W 331		
W 336	NURSING SERVICES CFR(s): 483.460(c)(3)(iii) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and document review the facility's nurse failed to ensure 1 of 3 clients (C1) was reviewed every quarter, (90 days apart) for	W 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G382	A. BUILDING _____ B. WING _____	C 09/30/2020

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SHINGLE CREEK OPTION	**5624 73RD AVE NO BROOKLYN PARK, MN 55429**

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W 336	Continued From page 14	W 336		

changes in health care status. In addition failed to ensure a yearly physical was completed by the physician for 1 of 3 clients (C1).

Findings include:

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 assessment had been completed August 2019, but did not address C1's falls since 2019.

During interview on 9/29/20, at 2:23 p.m. RN-A stated C1 was due for his annual physical but because of COVID-19 they agency had held off on it, even though C1 had been out of the facility for other appointments. RN-A stated she was unsure if C1 had seen his physician since last year. In regard to the quarterly review, RN-A stated she had not signed off on the completion of C1's quarterly reviews because she "just knows" what's going on.

DEPARTMENT OF HEALTH

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 (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.

Amy Johnson

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

DEPARTMENT OF HEALTH

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,

Amy Johnson

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