



Office of Health Facility Complaints Investigative Report  
PUBLIC

<b>Facility Name:</b> MTAI Minnehaha Creek			<b>Report Number:</b> HG439001	<b>Date of Visit:</b> November 9, 2017
<b>Facility Address:</b> 8949 48th Avenue North			<b>Time of Visit:</b> 8:30 a.m. to 2:30 p.m.	<b>Date Concluded:</b> December 29, 2017
<b>Facility City:</b> New Hope			<b>Investigator's Name and Title:</b> Rita Lucking, RN, Special Investigator	
<b>State:</b> Minnesota	<b>ZIP:</b> 55428	<b>County:</b> Hennepin		

☒ ICF/IID

**Allegation(s):**

It is alleged that Client #1 was neglected when facility staff failed to provide adequate supervision that resulted in Client #2 injuring Client #1's left hand. Client #1 required emergency medical services and hand surgery due to the injury.

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

**Conclusion:**

Based on a preponderance of the evidence, neglect occurred. Although two staff were working at the time of the incident, Client's #1 and #2 were left unsupervised in the kitchen. The facility failed to have an appropriate and effective method of monitoring and supervising the facility clients. Client #1 sustained a hand injury that required surgical intervention.

Client #1 has a history of severe developmental disability, anxiety, autism, and a seizure disorder.

Client #2 has a history of mild developmental disability, fetal alcohol syndrome, and a conduct disorder.

Although two staff were working at the time of the incident, Client's #1 and #2 were left unsupervised in the kitchen, and Client #2 stabbed the top of Client #1's hand with a potato peeler that s/he removed from the kitchen drawer. Client #1 was later observed washing the blood off of his/her hand, and s/he said Client #2's name when asked who caused the injury. Client #2 later admitted that s/he inflicted the wound because in the recent past Client #1 had attempted to push Client #2's family member down the stairs during a visit. The facility's incident report and internal investigation of the incident indicated 911 was called immediately, and Client #1 was transported via ambulance to the hospital for care. Client #1 sustained a laceration of the

tendon in his/her left hand. The area was sutured and a sling was applied at the hospital. As a result of the incident, Client #1 required hand surgery to repair the laceration and needed to wear a cast to protect the area while it was healing.

Client #1 and Client #2 were unable to be interviewed at the time of the on-site investigation due to their cognitive status.

The incident report, internal investigation, and observation by the investigator at the time of the site visit indicated knives/sharp kitchen utensils were removed from the kitchen drawers and placed in the office area following the incident. In addition, the internal investigation indicated Client #2 would be closely supervised following the incident.

Further review of the incident revealed there was a four day delay in the facility reporting the incident to the Common Entry Point.

---

#### Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abuse                    | <input checked="" type="checkbox"/> Neglect | <input type="checkbox"/> Financial Exploitation                           |
| <input checked="" type="checkbox"/> Substantiated | <input type="checkbox"/> Not Substantiated  | <input type="checkbox"/> Inconclusive based on the following information: |

---

#### Mitigating Factors:

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

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

1) The facility's policies and procedures did not provide an appropriate and effective method of monitoring and supervising clients with varying levels of developmental disabilities and who are at risk of becoming aggressive and injuring each other. 2) The facility's policies and procedures did not provide an appropriate and effective method of reporting possible maltreatment and injuries sustained by clients.

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

#### Compliance:

Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) - Compliance Not Met

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

Deficiencies are issued on form 2567: ☒ Yes ☐ No

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

**State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met**

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

State licensing orders were issued: ☒ Yes ☐ No

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

**State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met**

The requirements under State Statutes for Chapters 144 & 144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

**Compliance Notes:**

**Definitions:**

**Minnesota Statutes, section 626.5572, subdivision 17 - Neglect**

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

**Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated**

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

**The Investigation included the following:**

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

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Treatment Sheets
- ☒ Physician Progress Notes
- ☒ Care Plan Records
- ☒ Facility Incident Reports
- ☒ Service Plan

**Other pertinent medical records:**

- ☒ Hospital Records

**Additional facility records:**

- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Internal Investigation Reports
- ☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: None

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

Specify: \_\_\_\_\_

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

☒ Yes ☐ No ☐ N/A

Specify: \_\_\_\_\_

**Interviews: The following interviews were conducted during the investigation:**

Interview with reporter(s) ☒ Yes ☐ No ☐ N/A

Specify: \_\_\_\_\_

If unable to contact reporter, attempts were made on:

Facility Name: MTAI Minnehaha Creek

Report Number: HG439001

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Interview with family: ☒ Yes ☐ No ☐ N/A Specify: \_\_\_\_\_

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

☐ Yes ☒ No ☐ N/A Specify: Both clients are developmentally impaired

Did you interview additional residents? ☒ Yes ☐ No

Total number of resident interviews: Two

Interview with staff: ☒ Yes ☐ No ☐ N/A Specify: \_\_\_\_\_

### Tennessee Warnings

Tennessee Warning given as required: ☒ Yes ☐ No

Total number of staff interviews: Four

Physician Interviewed: ☐ Yes ☒ No

Nurse Practitioner Interviewed: ☐ Yes ☒ No

Physician Assistant Interviewed: ☐ Yes ☒ No

Interview with Alleged Perpetrator(s): ☐ Yes ☐ No ☒ N/A Specify: \_\_\_\_\_

Attempts to contact:

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

If unable to contact was subpoena issued: ☐ Yes, date subpoena was issued \_\_\_\_\_ ☐ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify \_\_\_\_\_

### Observations were conducted related to:

☒ Personal Care

☒ Cleanliness

☒ Dignity/Privacy Issues

☒ Safety Issues

☒ Facility Tour

☒ Other: kitchen (storage of knives, potato peeler)

Was any involved equipment inspected: ☒ Yes ☐ No ☐ N/A

Was equipment being operated in safe manner: ☒ Yes ☐ No ☐ N/A

Were photographs taken: ☐ Yes ☒ No Specify: \_\_\_\_\_

Facility Name: MTAI Minnehaha Creek

Report Number: HG439001

cc:

**Health Regulation Division - Licensing & Certification**

**The Office of Ombudsman for Mental Health and Developmental Disabilities**

**New Hope Police Department**

**Hennepin County Attorney**

**New Hope City Attorney**

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24G439</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTAI MINNEHAHA CREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8949 48TH AVENUE NORTH</b> <b>NEW HOPE, MN 55428</b>		
(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 000	INITIAL COMMENTS	W 000			
W 149	<p>A complaint investigation was conducted to investigate case #HG439001. As a result, the following deficiencies are issued.</p> <p><b>STAFF TREATMENT OF CLIENTS</b> CFR(s): 483.420(d)(1)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect and abuse for one of three clients, C1, who was reviewed. C1 sustained a laceration and tendon damage when C1 and C2 were left unsupervised in the kitchen, and C2 stabbed the top of C1's left hand with a potato peeler during meal preparation. Findings include:</p> <p>Medical record review indicated C1 was admitted to the facility with multiple diagnoses, including severe developmental disabilities, autism, anxiety and seizures.</p> <p>Medical record review indicated C2 was admitted to the facility with multiple diagnoses, including mild developmental disabilities and conduct disorder.</p> <p>C1's Individual Abuse Prevention Plan, dated 6/27/17, was reviewed and indicated C1 was assessed as being at risk for abuse due to his cognitive limitations.</p>	W 149			

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

TITLE

(X6) DATE

12/15/2017

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24G439</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTAI MINNEHAHA CREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8949 48TH AVENUE NORTH</b> <b>NEW HOPE, MN 55428</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 149	<p>Continued From page 1</p> <p>C2's individual Abuse Prevention Plan, dated 1/5/17, was reviewed and indicated C2 was assessed as being at risk for abuse due to his cognitive limitations.</p> <p>Review of two Incident Response Reporting Forms involving C1 and C2 indicated C1 sustained a serious laceration on the top of his left hand on 10/21/17 @ 7:30 p.m. The reports indicated C2 stabbed C1's hand with a potato peeler that C2 had removed from the drawer in the kitchen. The two clients had been left unsupervised in the kitchen when the incident occurred. Due to the seriousness of the laceration, staff called 911, and C1 was transported to the hospital for care. C2 admitted on 10/22/17 that he stabbed C1's left hand with the potato peeler. The two reporting forms indicated the Common Entry Point must be notified within 24 hours of the incident. Review of the two forms indicated the incident was not reported to the Common Entry Point until 10/25/17 @ 11:30 a.m.</p> <p>Review of C1's 10/21/17 emergency department record indicated C1 sustained an extensor tendon laceration on his left hand as a result of being stabbed with a potato peeler. The record indicated C1 was scheduled to have hand surgery on 10/27/17 and would wear a splint until the surgery.</p> <p>The policy titled Maltreatment Reporting, provided by the facility and revised June 2013 was reviewed. The policy under REPORTING ABUSE &amp; NEGLECT included: "As mandated reporters, any Mary T. Inc. employee who knows or suspects that a vulnerable adult or minor has been maltreated, must report this immediately (as</p>	W 149			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24G439</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTAI MINNEHAHA CREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8949 48TH AVENUE NORTH</b> <b>NEW HOPE, MN 55428</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 149	Continued From page 2  soon as possible following the incident). Employees can report directly to the Child Protection or the Common Entry Point where the alleged maltreatment occurred. When an internal report is received, the member of the internal investigation team assigned to the program is responsible for determining if the report must be forwarded to the Common Entry Point or Child Protection."	W 149			
W 153	Program Director (PD)/(A) was interviewed in person on 11/9/17 and stated employees (C) and (D) were working at the time of the incident. Clients #1 and #2 did not have physician orders that directed staff to monitor the two clients on a one to one basis prior to the incident. The two staff were not in the kitchen at the time of the incident. When staff asked C1 how the incident occurred, C1 responded by repeating C2's name several times, but C2 denied having any knowledge of how the injury occurred. C2 initially denied that he stabbed C1's hand with the potato peeler on 10/21/17 but admitted it on 10/22/17. The potato peeler and knives were removed from the kitchen drawer and placed in a locked office in the basement following the incident. The incident was not reported to the Common Entry point until 10/25/17. A mandatory staff meeting occurred on 10/26/17. Topics covered in the meeting included sharp utensils being locked up and out of reach of clients, the need to closely monitor C2 and appropriate reporting of incidents to the Common Entry Point.  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	W 153			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24G439</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTAI MINNEHAHA CREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8949 48TH AVENUE NORTH</b> <b>NEW HOPE, MN 55428</b>		
(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 153	<p>Continued From page 3</p> <p>injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure that injuries of unknown source are reported immediately in accordance with State law through established procedures for 1 of 3 clients reviewed. Client #1 (C1) sustained a deep laceration on the top of his left hand on 10/21/17 at 7:30 p.m. while he was unsupervised in the facility's kitchen.</p> <p>Medical record review indicated C1 was admitted to the facility with multiple diagnoses, including severe developmental disabilities, autism, anxiety and seizures.</p> <p>Medical record review indicated C2 was admitted to the facility with multiple diagnoses, including mild developmental disabilities and conduct disorder.</p> <p>C1's Individual Abuse Prevention Plan, dated 6/27/17, was reviewed and indicated C1 was assessed as being at risk for abuse due to his cognitive limitations.</p> <p>C2's individual Abuse Prevention Plan, dated 1/5/17, was reviewed and indicated C2 was assessed as being at risk for abuse due to his cognitive limitations.</p> <p>Review of two Incident Response Reporting Forms involving C1 and C2 indicated C1 sustained a serious laceration on the top of his</p>	W 153			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24G439</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTAI MINNEHAHA CREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8949 48TH AVENUE NORTH</b> <b>NEW HOPE, MN 55428</b>		
(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 153	<p>Continued From page 4</p> <p>left hand on 10/21/17 @ 7:30 p.m. The reports indicated C2 stabbed C1's hand with a potato peeler that C2 had removed from the drawer in the kitchen. The two clients had been left unsupervised in the kitchen when the incident occurred. Due to the seriousness of the laceration, staff called 911, and C1 was transported to the hospital for care. C2 admitted on 10/22/17 that he stabbed C1's left hand with the potato peeler. The two reporting forms indicated the Common Entry Point must be notified within 24 hours of the incident. Review of the two forms indicated the incident was not reported to the Common Entry Point until 10/25/17 @ 11:30 a.m.</p> <p>Review of C1's 10/21/17 emergency department record indicated C1 sustained an extensor tendon laceration on his left hand as a result of being stabbed with a potato peeler. The record indicated C1 was scheduled to have hand surgery on 10/27/17 and would wear a splint until the surgery.</p> <p>The policy titled Maltreatment Reporting, provided by the facility and revised June 2013 was reviewed. The policy under REPORTING ABUSE &amp; NEGLECT included: "As mandated reporters, any Mary T. Inc. employee who knows or suspects that a vulnerable adult or minor has been maltreated, must report this immediately (as soon as possible following the incident). Employees can report directly to the Child Protection or the Common Entry Point where the alleged maltreatment occurred. When an internal report is received, the member of the internal investigation team assigned to the program is responsible for determining if the report must be forwarded to the Common Entry Point or Child</p>	W 153			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24G439</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTAI MINNEHAHA CREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8949 48TH AVENUE NORTH</b> <b>NEW HOPE, MN 55428</b>		
(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 153	Continued From page 5 Protection."  Program Director (PD)/(A) was interviewed in person on 11/9/17 and stated employees (C) and (D) were working at the time of the incident. Clients #1 and #2 did not have physician orders that directed staff to monitor the two clients on a one to one basis prior to the incident. The two staff were not in the kitchen at the time of the incident. When staff asked C1 how the incident occurred, C1 responded by repeating C2's name several times, but C2 denied having any knowledge of how the injury occurred. C2 initially denied that he stabbed C1's hand with the potato peeler on 10/21/17 but admitted it on 10/22/17. The potato peeler and knives were removed from the kitchen drawer and placed in a locked office in the basement following the incident. The incident was not reported to the Common Entry point until 10/25/17. A mandatory staff meeting occurred on 10/26/17. Topics covered in the meeting included sharp utensils being locked up and out of reach of clients, the need to closely monitor C2 and appropriate reporting of incidents to the Common Entry Point.	W 153			



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Certified Mail # 70151660000041498358

December 15, 2017

Ms Mary Tjosvold, Administrator  
Mtai Minnehaha Creek  
8949 48th Avenue North  
New Hope, MN 55428

Re: Enclosed Federal Certification Deficiencies, Complaint Number HG439001

Dear Ms Tjosvold:

On November 21, 2017, a complaint investigation was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints, 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 investigator team noted one or more deficiencies.

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

To be considered acceptable, your PoC must contain the following elements:

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

The PoC must be placed directly on the CMS-2567 and 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 this letter and all documents submitted as a response to the client care deficiencies i.e., the plan of correction should be directed to:

Lindsey Krueger, RN, Supervisor  
Office of Health Facility Complaints  
Health Regulation Division  
85 East Seventh Place, Suite 220  
P.O. Box 64970  
St. Paul, MN 55164-0970  
Telephone: (651) 201-4135 Fax: (651) 281-9796  
General Information: (651) 201-4201 - 1-800-369-7994

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.

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,

A handwritten signature in cursive script that reads "Lindsey L. Krueger".

Lindsey Krueger, Supervisor  
Office of Health Facility Complaints  
Health Regulation Division  
85 East Seventh Place, Suite 220  
P.O. Box 64970  
St. Paul, MN 55164-0970  
Telephone: (651) 201-4215 Fax: (651) 281-9796

LK

Enclosure

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**MTAI MINNEHAHA CREEK**

**8949 48TH AVENUE NORTH  
NEW HOPE, MN 55428**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
5 000	<p>Initial Comments</p> <p>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.</p> <p>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.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. A complaint investigation was conducted to investigate case #HG439001. As a result, the following correction order is issued.</p>	5 000		
5 700	<p>MN Statute 144.651 Subd. 14. RES. RIGHTS Freedom from maltreatment.</p> <p>Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the</p>	5 700		

Minnesota Department of Health

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

TITLE

(X6) DATE

12/15/17

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**MTAI MINNEHAHA CREEK**

**8949 48TH AVENUE NORTH  
NEW HOPE, MN 55428**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
5 700	<p>Continued From page 1</p> <p>intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of three clients reviewed, C1, was free from maltreatment when C1 was neglected when C1 sustained a laceration and tendon damage when C1 and C2 were left unsupervised in the kitchen, and C2 stabbed the top of C1's left hand with a potato peeler during meal preparation.</p> <p>Findings include:</p> <p>Medical record review indicated C1 was admitted to the facility with multiple diagnoses, including severe developmental disabilities, autism, anxiety and seizures.</p> <p>Medical record review indicated C2 was admitted to the facility with multiple diagnoses, including mild developmental disabilities and conduct disorder.</p> <p>C1's Individual Abuse Prevention Plan, dated 6/27/17, was reviewed and indicated C1 was assessed as being at risk for abuse due to his</p>	5 700		



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTAI MINNEHAHA CREEK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8949 48TH AVENUE NORTH NEW HOPE, MN 55428</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
5 700	<p>Continued From page 2</p> <p>cognitive limitations.</p> <p>C2's individual Abuse Prevention Plan, dated 1/5/17, was reviewed and indicated C2 was assessed as being at risk for abuse due to his cognitive limitations.</p> <p>Review of two Incident Response Reporting Forms involving C1 and C2 indicated C1 sustained a serious laceration on the top of his left hand on 10/21/17 @ 7:30 p.m. The reports indicated C2 stabbed C1's hand with a potato peeler that C2 had removed from the drawer in the kitchen. The two clients had been left unsupervised in the kitchen when the incident occurred. Due to the seriousness of the laceration, staff called 911, and C1 was transported to the hospital for care. C2 admitted on 10/22/17 that he stabbed C1's left hand with the potato peeler. The two reporting forms indicated the Common Entry Point must be notified within 24 hours of the incident. Review of the two forms indicated the incident was not reported to the Common Entry Point until 10/25/17 @ 11:30 a.m.</p> <p>Review of C1's 10/21/17 emergency department record indicated C1 sustained an extensor tendon laceration on his left hand as a result of being stabbed with a potato peeler. The record indicated C1 was scheduled to have hand surgery on 10/27/17 and would wear a splint until the surgery.</p> <p>The policy titled Maltreatment Reporting, provided by the facility and revised June 2013 was reviewed. The policy under REPORTING ABUSE &amp; NEGLECT included: "As mandated reporters, any Mary T. Inc. employee who knows or suspects that a vulnerable adult or minor has</p>	5 700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTAI MINNEHAHA CREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8949 48TH AVENUE NORTH NEW HOPE, MN 55428</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
5 700	<p>Continued From page 3</p> <p>been maltreated, must report this immediately (as soon as possible following the incident). Employees can report directly to the Child Protection or the Common Entry Point where the alleged maltreatment occurred. When an internal report is received, the member of the internal investigation team assigned to the program is responsible for determining if the report must be forwarded to the Common Entry Point or Child Protection."</p> <p>Program Director (PD)/(A) was interviewed in person on 11/9/17 and stated employees (C) and (D) were working at the time of the incident. Clients #1 and #2 did not have physician orders that directed staff to monitor the two clients on a one to one basis prior to the incident. The two staff were not in the kitchen at the time of the incident. When staff asked C1 how the incident occurred, C1 responded by repeating C2's name several times, but C2 denied having any knowledge of how the injury occurred. C2 initially denied that he stabbed C1's hand with the potato peeler on 10/21/17 but admitted it on 10/22/17. The potato peeler and knives were removed from the kitchen drawer and placed in a locked office in the basement following the incident. The incident was not reported to the Common Entry point until 10/25/17. A mandatory staff meeting occurred on 10/26/17. Topics covered in the meeting included sharp utensils being locked up and out of reach of clients, the need to closely monitor C2 and appropriate reporting of incidents to the Common Entry Point.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	5 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTAI MINNEHAHA CREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8949 48TH AVENUE NORTH NEW HOPE, MN 55428</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
5 815	Continued From page 4	5 815			
5 815	<p>MN Statute 626.557 Subd. 3. VA Timing of report.</p> <p>(a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:</p> <p>(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or</p> <p>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).</p> <p>(b) A person not required to report under the provisions of this section may voluntarily report as described above.</p> <p>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p> <p>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the</p>	5 815			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTAI MINNEHAHA CREEK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8949 48TH AVENUE NORTH NEW HOPE, MN 55428</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
5 815	<p>Continued From page 5</p> <p>reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that injuries of unknown source are reported immediately in accordance with State law through established procedures for 1 of 3 clients reviewed. Client #1 (C1) sustained a deep laceration on the top of his left hand on 10/21/17 at 7:30 p.m. while he was unsupervised in the facility's kitchen.</p> <p>Medical record review indicated C1 was admitted to the facility with multiple diagnoses, including severe developmental disabilities, autism, anxiety and seizures.</p> <p>Medical record review indicated C2 was admitted to the facility with multiple diagnoses, including mild developmental disabilities and conduct disorder.</p> <p>C1's Individual Abuse Prevention Plan, dated 6/27/17, was reviewed and indicated C1 was assessed as being at risk for abuse due to his cognitive limitations.</p> <p>C2's individual Abuse Prevention Plan, dated 1/5/17, was reviewed and indicated C2 was assessed as being at risk for abuse due to his</p>	5 815		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**MTAI MINNEHAHA CREEK**

**8949 48TH AVENUE NORTH  
NEW HOPE, MN 55428**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
5 815	<p>Continued From page 6</p> <p>cognitive limitations.</p> <p>Review of two Incident Response Reporting Forms involving C1 and C2 indicated C1 sustained a serious laceration on the top of his left hand on 10/21/17 @ 7:30 p.m. The reports indicated C2 stabbed C1's hand with a potato peeler that C2 had removed from the drawer in the kitchen. The two clients had been left unsupervised in the kitchen when the incident occurred. Due to the seriousness of the laceration, staff called 911, and C1 was transported to the hospital for care. C2 admitted on 10/22/17 that he stabbed C1's left hand with the potato peeler. The two reporting forms indicated the Common Entry Point must be notified within 24 hours of the incident. Review of the two forms indicated the incident was not reported to the Common Entry Point until 10/25/17 @ 11:30 a.m.</p> <p>Review of C1's 10/21/17 emergency department record indicated C1 sustained an extensor tendon laceration on his left hand as a result of being stabbed with a potato peeler. The record indicated C1 was scheduled to have hand surgery on 10/27/17 and would wear a splint until the surgery.</p> <p>The policy titled Maltreatment Reporting, provided by the facility and revised June 2013 was reviewed. The policy under REPORTING ABUSE &amp; NEGLECT included: "As mandated reporters, any Mary T. Inc. employee who knows or suspects that a vulnerable adult or minor has been maltreated, must report this immediately (as soon as possible following the incident). Employees can report directly to the Child Protection or the Common Entry Point where the alleged maltreatment occurred. When an internal</p>	5 815		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTAI MINNEHAHA CREEK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8949 48TH AVENUE NORTH NEW HOPE, MN 55428</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
5 815	<p>Continued From page 7</p> <p>report is received, the member of the internal investigation team assigned to the program is responsible for determining if the report must be forwarded to the Common Entry Point or Child Protection."</p> <p>Program Director (PD)/(A) was interviewed in person on 11/9/17 and stated employees (C) and (D) were working at the time of the incident. Clients #1 and #2 did not have physician orders that directed staff to monitor the two clients on a one to one basis prior to the incident. The two staff were not in the kitchen at the time of the incident. When staff asked C1 how the incident occurred, C1 responded by repeating C2's name several times, but C2 denied having any knowledge of how the injury occurred. C2 initially denied that he stabbed C1's hand with the potato peeler on 10/21/17 but admitted it on 10/22/17. The potato peeler and knives were removed from the kitchen drawer and placed in a locked office in the basement following the incident. The incident was not reported to the Common Entry point until 10/25/17. A mandatory staff meeting occurred on 10/26/17. Topics covered in the meeting included sharp utensils being locked up and out of reach of clients, the need to closely monitor C2 and appropriate reporting of incidents to the Common Entry Point.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	5 815		



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Certified Mail # 70151660000041498358

12/15/2017

Ms. Mary Tjosvold, Administrator  
Mtai Minnehaha Creek  
8949 48th Avenue North  
New Hope, MN 55428

Re: Enclosed State Licensing Orders and Federal Certification Deficiencies - Complaint Number  
HG439001

Dear Ms. Tjosvold:

A complaint investigation abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints, on November 21, 2017 for the purpose of assessing compliance with state licensing rules in accordance with the Vulnerable Adults Act related to complaint number HG439001 and federal certification regulations. At the time of the investigation, the investigator noted one or more violations.

Fed - W - 0000 - - Initial Comments

Fed - W - 0149 - 483.420(d)(1) - Staff Treatment Of Clients

Fed - W - 0153 - 483.420(d)(2) - Staff Treatment Of Clients

St - 5 - 0000 - - Initial Comments

St - 5 - 0700 - Mn Statute 144.651 Subd. 14. - Res. Rights Freedom From Maltreatment.

St - 5 - 0815 - Mn Statute 626.557 Subd. 3. - Va Timing Of Report.

The Federal certification deficiencies are delineated on the 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.

To be considered acceptable, your PoC must contain the following elements:

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

The plan must be specific, realistic, include date certain for correction for each deficiency and signed by

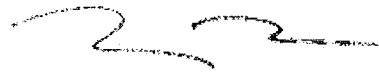
the administrator or other authorized official of the facility. Ordinarily, a provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit date. If possible, please type your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original to the above address.

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.

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,



(Michelle Ness)

Michelle Ness, R.N., B.S., P.H.N.,  
Assistant Director  
Office of Health Facility Complaints  
85 East Seventh Place, Suite 220  
P.O. Box 64970  
St. Paul, MN 55164-0970  
Telephone: (651) 201-4217 Fax: (651) 281-9796

LK

Enclosure

cc: Licensing and Certification File

State licensing orders are delineated on the attached Minnesota Department of Health form. The form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, and if you find that any of the orders are not in accordance with your understanding, you should contact me or the investigator. A written plan for correction of licensing orders is not required.