Emailed April 7, 2020

Administrator
Laura Baker Services Association
211 Oak Street
Northfield, MN 55057

RE: Event ID: SKI111

Dear Administrator:

On March 9, 10 and 11, 2020 an abbreviated survey was completed to investigate complaints #HG500041C, HG500042C, HG500043C, HG500044C and HG500045C. Laura Baker is not compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.

HG500041C, HG500043C, HG500044C and HG500045C were found to be unsubstantiated.

HG500042C was found to be substantiated

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.

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

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

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

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

correction should be directed to:

Karen Aldinger, RN
HFE-Unit Supervisor, Metro Team A
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Office: 651-201-3794 | Mobile: 320-249-2805

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

(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 On March 9, 10 and 11, 2020 an abbreviated survey was completed to investigate complaints #HG500041C, HG500042C, HG500043C, HG500044C and HG500045C. Laura Baker is not compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. HG500041C, HG500043C, HG500044C and HG500045C were unsubstantiated. . HG500042C was substantiated at W154 and W155	W 000		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 2 clients (C1) who had an injury of unknown origin. Findings include: On 3/11/2020, at 9:57 a.m., Lead direct care staff (LDC)-A stated during interview, that on 2/20/2020 at around 4:00 p.m., C3 indicated C3 was bleeding. C3 had been seen by facility registered nurse (RN) earlier and had bandages placed over abraised areas. LDC-A assisted C3 and changed the bandages, and C3 indicated Night resident counselor (NRC) -A "escorted her	W 154	All internal investigations for the past 30 days will be reviewed using the internal investigation checklist to assure a complete and thorough investigation. This will be completed by May 7th 2020 by the program mandated reporter. Director of Oak street services is responsible for assuring completion. An internal investigation checklist has been developed which will be used to assure a thorough investigation. Retraining on the policies and procedures for program mandated reporter has been conducted by 4/13/20 by Director of Oak Street Services. The internal investigation checklist will be attached to each internal investigation ensuring easy review by the facility administrator. The Director of Oak street services is responsible to assure completion.	

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

Director of Oak St. Services 4/13/20

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.

Karen Gaidry 4/20/20

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W 154	Continued From page 1 to her room, after she was naughty." C3 said he/she was dragged by her/his night staff and pointed to her/his left arm. LDC-A indicated Program Support staff (PSS)-A was called and the incident was reported. LDC-A indicated PSS-A directed a scomm (internal email) be sent to PSS-A. Review of the general event report (GER) opened 2/23/2020, indicated NRC-A, RN-A, LDC-A, and residential counselor (RC) -A were interviewed on 2/20/2020, and other staff were not interviewed until 2/23/2020. C3 was not interviewed by PSS-A until 2/23/2020. Interview with PSS-A on 3/10/2020 indicated that he thought C3 was "not a reliable reporter" and no other interviews were needed at that time. PSS-A verified the dates and times of the interviews with other staff. NRC-A was not removed from the schedule, and continued to work for the facility The area director provided the surveyor with a copy of the facility's investigation. Although the investigation included interviews with facility staff, the interviews were held 2 days later. The facility's investigation concluded rough treatment of C1 by NRC-A was inconclusive, as per PSS-A, C3 was not a reliable reporter. Review of C3's Identification Data form received 3/11/2020 indicated C3's diagnosis to included moderate intellectual disabilities, bipolar disorder,and anemia. The facility's policy addressing the prevention and reporting of individual maltreatment, dated 12/3/2019 read: "Procedure for conducting an internal investigation. The investigating team will conduct the investigation including: 4) Observe the alleged victim. As appropriate, interview the	W 154		

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W 154	Continued From page 2 victim. 5) If the report alleges abuse or neglect by a caregiver, determine if the caregiver is a threat to the alleged victim or others. Take action to separate the alleged victim and the alleged perpetrator. Pending the results of the investigation, the individual completing the internal investigation my place any staff involved on administrative leave. 8)gather written statements from any witnesses and all staff who worked during the time the alleged incident took place, including night staff members:..."; 3) Review of other pertinent factors;..."	W 154		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to ensure safety and supervision was provided per facility policy during the investigative process for abuse for 1 of 1 client (C3), after C3 told staff the night resident counselor (NRC)- A had dragged her the night before. Findings include: On 3/11/2020, at 9:57 a.m., Lead direct care staff (LDC)-A stated during interview, that on 2/20/2020 at around 4:00 p.m., C3 indicated C3 was bleeding. C3 had been seen by facility registered nurse (RN) earlier and had bandages placed over abraised areas. LDC-A assisted C3 and changed the bandages, and C3 indicated NRC -A "escorted her to her room, after she was	W 155	All internal investigations for the past 30 days will be reviewed using the internal investigation checklist to assure a complete and thorough investigation. This will be completed by May 7th 2020 by the program mandated reporter. Director of Oak street services is responsible for assuring completion. An internal investigation checklist has been developed which will be used to assure a thorough investigation including taking immediate action. Retraining on the policies and procedures for program mandated reporter has been conducted by 4/13/20 by Director of Oak Street Services. The internal investigation checklist will be attached to each internal investigation ensuring easy review by the facility administrator. The Director of Oak street services is responsible to assure completion and immediate action was taken.	

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W 155	Continued From page 4 victim. 5) If the report alleges abuse or neglect by a caregiver, determine if the caregiver is a threat to the alleged victim or others. Take action to separate the alleged victim and the alleged perpetrator. Pending the results of the investigation, the individual completing the internal investigation my place any staff involved on administrative leave. 8) gather written statements from any witnesses and all staff who worked during the time the alleged incident took place, including night staff members:..."; 3) Review of other pertinent factors;..."	W 155		

Incident: Date:

☐ Report incident to outside agency
☐ Take immediate action to protect individual
    ☐ If the alleged perpetrator is a staff member, the staff member shall be placed on leave beginning immediately
        ☐ Assure proper coverage for household if needed
    ☐ Make immediate environmental changes if needed to protect safety of individual
☐ Notify the alleged perpetrator in writing that a maltreatment report alleging them as the perpetrator has been filed
☐ Notify the clients legal representative and case manager a report has been generated within 24 hours Including:
        ☐ Nature of the occurrence that led to the report
        ☐ The agency that received the report
        ☐ Telephone number of the DHS licensing division
☐ Get written & signed statements from all individuals (including client if able) involved within 24 hours
☐ Review written statements, ask any objective, follow up questions if needed, take pictures if needed & observe alleged victim - see questions for reporting
    ☐ Upload all written statements to GER resolution
    ☐ For interviews:
        ☐ Have 2 people present
        ☐ Document all questions and responses in written form, upload to GER resolution
    ☐ For observations:
        ☐ Use staff quality assurance checklist
    ☐ For pictures:
        ☐ Attach a picture of any injury to the GER
☐ Provide initial reporter with written notice whether LBSA reported incident to MAARC within 2 working days – addendum A notice of report of suspected maltreatment
☐ Assure GER is complete including:
    ☐ Correct report of incident
    ☐ All notifications were made and documented
    ☐ Abuse/neglect is selected
    ☐ Approve GER once all information is correct
☐ After all facts are gathered make a determination of changes needed
☐ Create a corrective plan to assure no more future occurrences
    ☐ Corrective plan can include but is not limited to: staff discipline including up to termination, retraining, policy changes, ISP changes or environmental changes
    ☐ Place recommendations on the GER resolution, identify each person responsible and completion due date
☐ Follow up with each individual responsible for each corrective action to assure completion and implementation.
    ☐ Document on GER resolution
☐ create and complete all training as needed

☐ Place a copy of internal investigation and any follow up training/corrections (i.e. disciplinary actions) in the employee's file

Staff Quality Assurance Checklist

Staff Name:_____ Date:_____ Observer Name:_____

Mealtime observed: ☐ Yes ☐ No

Question	Yes	No	N/A	Comments/Corrective Actions Taken
Was the environment safe & did staff follow clients ISSA, IAPP, BSP, Restrictions list etc.				
If Target Behaviors occurred, was staff able to implement necessary intervention according to BSP?				
Did staff reinforce appropriate behavior?				
Were goals and objectives implemented as written?				
Was appropriate prompting used?				
Was data recorded in Therap?				
Was a Tlog written?				
Was staff encouraging clients to be as independent as possible?				
Did the client have choices/Were staff encouraging choices?				
Was staff available to assist the client when necessary?				
Did staff follow any dietary restrictions/plans for this client?				
Did staff know the client's schedule?				
Was social interaction appropriate?				

Did client participate in family style dining?				
Was the client's appearance and personal space tidy?				
Was the client treated with dignity and respect?				
Did staff respect client privacy?				
Did staff provide active treatment?				
Were policies and procedures related to maltreatment followed?				
Were medication administration procedures followed? Including keeping keys locked				
Did Client have any visible injuries (bruising, scratching etc.)				
Was staff on their cell phone?				
Crisis Management – Give staff a scenario and ask if it would warrant a restraint. Write Scenario and staff answer in comments section.				
Problem Solving – Give staff a scenario and ask them to come up with at least 2 different ways to solve the problem. Write Scenario and staff answer in comments section				

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 7, 2020

Administrator
Laura Baker Services Association
211 Oak Street
Northfield, MN 55057

Event ID: SKI111

Dear Administrator:

On March 9, 10, and 11, 2020, complaint investigations were conducted to investigate complaints #HG500041C, HG500042C, HG500043C, HG500044C, and HG500045C. Laura Baker Services Association is in full compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please note it is your responsibility to share the information contained in this letter and the results of this 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: 651-215-9697

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01163	A. BUILDING: _____ B. WING _____	C 03/11/2020

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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 March 9, 10, and 11, 2020, complaint investigations were conducted to investigate complaints #HG500041C, HG500042C, HG500043C, HG500044C, and HG500045C. Laura Baker Services Association is in full compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).	5 000		