Emailed August 13, 2020

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

RE: Event ID: X1CR11
Project numbers: HG500056C, HG500059C

Dear Administrator:

During this period of pandemic COVID-19 outbreak, State Agencies (MDH) are changing the process for survey prioritization and enforcement remedies. MDH is delaying revisit surveys and are exercising enforcement discretion during this prioritization period, beginning March 23, 2020. As a result, the below enforcement actions resulting from this survey cycle will be suspended until revisits are again authorized.

This letter also requests that your facility submit a plan of correction. Although revisit surveys will not be conducted during the prioritization period, you may still submit your facility's POC during this time and the case will be held. Your facility may delay submission of a POC until the prioritization period is over.

On July 21, 2020 through July 23, 2020, an abbreviated survey was conducted to investigate HG500056C and HG500059C. The facility was found not to be in compliance with the requirements of 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID).

HG500056C was substantiated with deficiencies issued.
HG500059C was substantiated with no deficiencies issued.

One or more of these deficiencies do not 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): This is listed below.

W-0122 Client Protection 42 CFR 483.420

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:

- 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:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356
Fax: 320-223-7348

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 **September 6, 2020**, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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: 651-215-9697

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed August 13, 2020

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

Re: Project Number: HG500056C, HG500059C
Evenit ID: XICR11

Dear Administrator:

The above facility survey was completed on July 23, 2020 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56.

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

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
	01163	A. BUILDING: _____ B. WING _____	C 07/23/2020

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) COMPLETE DATE
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 7/21/20 through 7/23/20, an abbreviated survey was completed to investigate complaint HG500056C and HG500059C. The complaints were found to be substantiated. No licensing orders were issued. Your facility is in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).	5 000		

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W 000	INITIAL COMMENTS On 7/21/20 through 7/23/20, an abbreviated survey was conducted to investigate HG500056C and HG500059C. The facility was found not to be in compliance with the requirements of 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID). In addition, the Condition of Participation: Client Protection 42 CFR 483.420 found not met. HG500056C was substantiated with deficiencies issued at W122, W127, HG500059C was substantiated with no deficiencies issued. As a result of the complaint investigations deficiencies were also identified at W153 and W154.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed to protect a client who was being verbally abused by a staff member that was not immediately reported or protected for 1 of 1 clients (C20) reviewed for abuse.	W 122		

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

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W 122	Continued From page 1 Findings include: See W127: The facility failed to protect a client from verbal abuse from staff for 1 of 1 clients (C20) reviewed for abuse.	W 122		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to protect a client from abuse when a staff member was alleged to make verbal threats to hurt a client for 1 of 1 clients (C20) reviewed for abuse. Findings include: C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980. The EDF further indicated he had profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal. C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP	W 127		

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W 127	Continued From page 2	W 127		

indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff.

A Common Entry Report (CEP) dated 7/13/20, reported by qualified developmental disability professional (QDDP)-R indicated, "On Monday, July 13th, the household director where [C20] lives notified QDDP, that a previous staff [DSS-J] had reported some verbal threats directed towards [C20] from another staff person. The person reporting said that she heard direct support staff [DSS-X] threaten to "break [C20]'s teeth" or "break [C20]'s fingers." The person reporting said that during the incident, [C20] bit [DSS-X] and [DSS-X] told [C20] if he kept doing that she would "break his teeth." The report further went on to indicate C20 kept pointing at DSS-X and poking at her and she told him if he kept doing that she would break his fingers.

A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore, the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and staff who are employees could not confirm any threats to C20. The report did not indicate what QDDP-B's conclusion was but the report was closed and signed by the administrator on 7/17/20.

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W 127	Continued From page 3	W 127		

During interview on 7/21/20, at 9:30 a.m. with QDDP-R who stated she was informed of the allegation and called DSS-J to confirm if the allegation was true, adding DSS-J confirmed she had witnessed the verbal abuse and that DSS-J had not reported the allegation as required because she did not think DSS-X would actually hurt C20. C20 was unable to provide a specific date. QDDP-R stated she then notified QDDP-B of the incident who notified the administrator.

During interview on 7/21/20, at 1:00 p.m. QDDP-B stated following his investigation, he felt the report was inconclusive because he did not have any problems with DSS-X and she had no disciplinary actions in her employment file when he looked today. He further stated he made multiple attempts to reach DSS-J and she did not return his calls, even though QDDP-R told her I would be calling. DSS-X also denied the allegations. He summarized by stating, since he did hear back from DSS-J and had no concerns, he felt the investigation was inconclusive.

An addition, the GER Resolution dated 7/16/20, at 1:29 p.m. last updated by the director of oak street services (DOCS), indicated QDDP-B had several interviews dated 7/14/20 to 7/15/20 (no times documented) with staff, which concluded the following:

-Interview with DSS-X stated she has never threatened or told C20 she would harm him.

-Interview with HHD-P stated DSS-X has a loud and demanding voice.
-Interview with DSS-Y stated she had heard DSS-X use some name calling such as "brat" and some rough handling such as turning C20 away

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W 127	Continued From page 4	W 127		

from door. But did not think DSS-X was abusive but could be gentler when turning him.
-Interview with HHD-Q (former HHD) at North Oak who stated when DSS-X was impatient or frustrated with C20 she would offer to give her a break, she had counseled DSS-X about yelling at C20 in the past. She further indicated she would not schedule DSS-X for multiple days in a row to prevent burn-out because C20 can be challenging/exhausting.

A facility e-mail sent from QDDP-B to DSS-X, QDDP-R and director of oak creek services indicated, "An allegation was made that you verbally threatened a client. The internal review of this allegation is inconclusive and allegation was not sustain/proven. You are able to report to work as scheduled on Monday 7/20/20. I want to meet with you Monday morning to discuss recommendations I have made as a result of the internal review."

During observation 7/22/20, at 10:00 a.m. C20 was walking around in North Oak house. DSS-X was following him around going from room to room with him.

During interview 7/22/20, at 10:15 a.m. the facility administrator stated DSS-J had received training in reporting and should have immediately reported this incident to us (DSS-J no longer worked at the facility). In addition, after reviewing internal investigation notes, she stated while interviewing, QDDP-B should have asked staff more questions when they stated DSS-X had yelled, named called or was being rough to find out more information. Further more, she stated QDDP-B had received training in the past about keeping a open mind in his decisions while doing

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W 127	Continued From page 5	W 127		

his investigation and even though QDDP-R was the only one who received the interview from DSS-J about the allegation that should be enough. The administrator stated she will be following up with QDDP-B.

Review of DSS-X employee file indicated the following:

- Employee Disciplinary Report (EDR) dated 5/17/12, indicated DSS-X had improper conduct and violation of policy and procedures. The report indicated it was written warning. The report further indicated DSS-X was making abusive, hostile comments and directives to other staff and students (Laura Baker school with clients that attended).

-EDR dated 7/20/20, indicated incident 7/13/20, inappropriate interactions with clients. "During an internal review of an allegation, several persons indicated [DSS-X] may be exhausted and/or frustrated with client behavior and responded by yelling or using language that is contrary to treating clients with respect." The EDR indicated it was a written warning and consequence would be discipline up to and including termination signed by QDDP-B and DSS-X on 7/21/20.

QDDP-B's interval investigation was determined to be inconclusive despite having interviews from several interviews from staff stating she was loud, could be rough and was name calling, Furthermore, QDDP-B failed to asked additional questions of the staff when information was provided regarding potential rough handling and verbal abuse of clients by DSS-X.
In addition, DSS-X was allowed to return to work and work directly with C20 on 7/21/20 without

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W 127	Continued From page 6 adequate retraining of the abuse policy and procedure, without supervision and monitoring of her performance and interaction with clients and without adequate monitoring or enforcement of recommendation to ensure DSS-X was not be allowed to work excessive hours with C2. During interview 7/22/20, at 10:30 a.m. the director of oak services confirmed DSS-X was receiving training on vulnerable adult abuse and neglect policies today and a monitoring system was developed by management to ensure adequate oversight of her work hours and interacations with C20. The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 5/7/2020, indicated any employee or volunteer who has reason to believe a vulnerable adult or minor is being or has been maltreated must report it immediately. When the mandated reporter has reason to believe a report needs to be made, he/she must ensure clients are safe and have appropriate supervision. In addition the report indicated the program's mandated reporter or designee shall be responsible for reviewing and investigating the report, and directing or taking any and all actions to insure the safety of the vulnerable person, including, as appropriate, removing the alleged perpetrator from direct contact with the alleged victim.	W 127		
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	W 153		

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W 153	Continued From page 7 officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately contact the administrator and state agency for 1 of 1 clients (C20) alleged to have been verbally abused. Findings include: C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980 with a diagnosis of profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal. C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff. A Common Entry Report (CEP) dated 7/13/20, reported by qualified developmental disability professional (QDDP)-R, indicated "On Monday, July 13th, the household director where [C20] lives notified QDDP, that a previous staff (DSS-J) had reported some verbal threats directed towards [C20] from another staff person. The	W 153		

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W 153	Continued From page 8	W 153		

person reporting said that she heard direct support staff [DSS-X] threaten to "break [C20]'s teeth" or "break [C20]'s fingers." The person reporting said that during the incident, [C20] bit [DSS-X] and [DSS-X] told [C20] if he kept doing that she would "break his teeth". The report further went on to indicate C20 kept pointing at DSS-X and poking at her and she told him if he kept doing that she would break his fingers.

A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and no staff could confirm any threats to C20. Lastly this report indicted it was closed by the facility administrator on 7/17/20. The report did not indicate what QDDP-B's conclusion was but was signed by the administrator.

During interview 7/21/20 at 9:30 a.m. with QDDP-R who stated she was informed of the all allegation and called DSS-J to see it was true and she said yes and stated she did not report the incident to the state or the facility administrator. QDDP-R stated DSS-J was unsure the exact date but QDDP-R knew she started after COVID so it was sometime after March 2020 and she only worked here just a few months. QDDP-R then notified QDDP-B of the incident who notified the administrator.

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W 153	Continued From page 9 The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 5/7/2020, indicated any employee or volunteer who has reason to believe a vulnerable adult or minor is being or has been maltreated must report it immediately and ensure clients are safe and have appropriate supervision. In addition the policy indicated the administrator must be notified.	W 153		
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 allegations of abuse for 1 of 1 client (C20) reviewed for staff to client abuse. Findings include: C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980 with a diagnosis of profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal. C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting	W 154		

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	24G500	A. BUILDING _____ B. WING _____	C 07/23/2020

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 154	Continued From page 10	W 154		

procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff.

A Common Entry Report (CEP) dated 7/13/20, reported by qualified developmental disability professional (QDDP)-R, indicated "On Monday, July 13th, the household director where [C20] lives notified QDDP, that a previous staff (DSS-J) had reported some verbal threats directed towards [C20] from another staff person. The person reporting said that she heard direct support staff [DSS-X] threaten to "break [C20]'s teeth" or "break [C20]'s fingers." The person reporting said that during the incident, [C20] bit [DSS-X] and [DSS-X] told [C20] if he kept doing that she would "break his teeth". The report further went on to indicate C20 kept pointing at DSS-X and poking at her and she told him if he kept doing that she would break his fingers.

A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and staff who are employees could not confirm any threats to C20. Lastly this report indicted it was closed by the facility administrator on 7/17/20. The report did not

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W 154	Continued From page 11	W 154		

indicate what QDDP-B's conclusion was but the report was signed by the administrator.

During interview 7/21/20 at 1:00 p.m. QDDP-B stated he felt the report was inconclusive because he did not have any problems with DSS-X and had no disciplinary actions in her employee file when he looked today. He further stated he made multiple attempts to reach DSS-J and she did not return his calls even though QDDP-R told her he would be calling. DSS-X also denied the allegations. He then stated since he did hear back from DSS-J and had no concerns he felt the investigation was inconclusive. Furthermore QDDP-B stated he did not interview the other clients in the home and had no explanation as to why he did not include that as part of his process.

An addition, the GER Resolution dated 7/16/20, at 1:29 p.m. last updated by the director of oak street services, indicated QDDP-B had several interviews dated 7/14/20 to 7/15/20 with no times, with staff which concluded the following:

-Interview with HHD-P stated DSS-X has a loud and demanding voice.
-Interview with DSS-Y stated she has heard DSS-X use some name calling such as "brat" and some rough handling such as turning C20 away from door. But did not this DSS-X was abusive but could be gentler when turning him.
-Interview with DSS-X stated she has never threatened or told C20 she would harm him.
-Interview with HHD-Q (former HHD)at North Oak who stated when DSS-X was impatient or frustrated with C20 she would offer to give her a break, she had counseled DSS-X about yelling at C20 in the past. She further indicated she would

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W 154	Continued From page 12	W 154		

not schedule DSS-X for multiple days in a row to prevent burn-out because C20 can be challenging/exhausting.

Despite having several interviews from staff stating DSS-X was loud, could be rough with clients, and was observed calling clients names such as "brat", as well as gaining a history of previous concerns from her previous house supervisor of her direct behavior towards C20, QDDP-B's determination was inconclusive to abuse due to being unable to contact DSS-J himself (even though QDDP-R had already interviewed and received her report of the verbal abuse and physical threat made by DSS-X) and because there was not any history of concerns recorded in DSS-X's employee file. Further more QDDP-B failed to complete a thorough investigation when he did not inquire further regarding aggressive behavior reported during interviews gathered during the investigation and when QDDP-B failed to interview clients as part of the internal investigation.

A facility policy revised 5/7/20, indicated 5. After reporting the incident of alleged abuse/neglect to the MAARC [Minnesota Adult Abuse Reporting Center] the programs mandated reporter will begin the internal investigation. The program reporter is responsible for using the checklists included in this policy for conducting a fair and impartial investigation. The internal review will also include an evaluation of whether related policies and procedures were followed and whether or not they were adequate, if there is a need for additional staff training. Further the policy indicated "If the report alleges abuse or neglect by a care giver, determine if the caregiver is a threat to the alleged victim or others."

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W 000	INITIAL COMMENTS On 7/21/20 through 7/23/20, an abbreviated survey was conducted to investigate HG500056C and HG500059C. The facility was found not to be in compliance with the requirements of 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID). In addition, the Condition of Participation: Client Protection 42 CFR 483.420 found not met. HG500056C was substantiated with deficiencies issued at W122, W127, HG500059C was substantiated with no deficiencies issued. As a result of the complaint investigations deficiencies were also identified at W153 and W154.	W 000	POC 9/23/20 accepted 9/10/20	
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed to protect a client who was being verbally abused by a staff member that was not immediately reported or protected for 1 of 1 clients (C20) reviewed for abuse.	W 122		

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Facility Administrator — (X6) DATE: 8/22/20

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection, was not met. The facility failed to protect a client who was being verbally abused by a staff member that was not immediately reported or protected for 1 of 1 clients (C20) reviewed for abuse.	W 122	see 127	

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

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

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W 122	Continued From page 1 Findings include: See W127: The facility failed to protect a client from verbal abuse from staff for 1 of 1 clients (C20) reviewed for abuse.	W 122		9/23/20
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to protect a client from abuse when a staff member was alleged to make verbal threats to hurt a client for 1 of 1 clients (C20) reviewed for abuse. Findings include: C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980. The EDF further indicated he had profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal. C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP	W 127	All investigations will be reviewed for the past 90 days to assure all clients have been protected from abuse. All QDDP's will be trained by the facility administrator on policy of suspending staff immediately when a maltreatment report has been made. All investigations are reviewed by the executive director and facility administrator within 3 days.	9/23/20

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W 127	Continued From page 2 indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff. A Common Entry Report (CEP) dated 7/13/20, reported by qualified developmental disability professional (QDDP)-R indicated, "On Monday, July 13th, the household director where [C20] lives notified QDDP, that a previous staff [DSS-J] had reported some verbal threats directed towards [C20] from another staff person. The person reporting said that she heard direct support staff [DSS-X] threaten to "break [C20]'s teeth" or "break [C20]'s fingers." The person reporting said that during the incident, [C20] bit [DSS-X] and [DSS-X] told [C20] if he kept doing that she would "break his teeth." The report further went on to indicate C20 kept pointing at DSS-X and poking at her and she told him if he kept doing that she would break his fingers. A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore, the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and staff who are employees could not confirm any threats to C20. The report did not indicate what QDDP-B's conclusion was but the report was closed and signed by the administrator on 7/17/20.	W 127		

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W 127	Continued From page 3 During interview on 7/21/20, at 9:30 a.m. with QDDP-R who stated she was informed of the allegation and called DSS-J to confirm if the allegation was true, adding DSS-J confirmed she had witnessed the verbal abuse and that DSS-J had not reported the allegation as required because she did not think DSS-X would actually hurt C20. C20 was unable to provide a specific date. QDDP-R stated she then notified QDDP-B of the incident who notified the administrator. During interview on 7/21/20, at 1:00 p.m. QDDP-B stated following his investigation, he felt the report was inconclusive because he did not have any problems with DSS-X and she had no disciplinary actions in her employment file when he looked today. He further stated he made multiple attempts to reach DSS-J and she did not return his calls, even though QDDP-R told her I would be calling. DSS-X also denied the allegations. He summarized by stating, since he did hear back from DSS-J and had no concerns, he felt the investigation was inconclusive. An addition, the GER Resolution dated 7/16/20, at 1:29 p.m. last updated by the director of oak street services (DOCS), indicated QDDP-B had several interviews dated 7/14/20 to 7/15/20 (no times documented) with staff, which concluded the following: -Interview with DSS-X stated she has never threatened or told C20 she would harm him. -Interview with HHD-P stated DSS-X has a loud and demanding voice. -Interview with DSS-Y stated she had heard DSS-X use some name calling such as "brat" and some rough handling such as turning C20 away	W 127	All investigations will be reviewed for the past 90 doays. to assure completion The Facility administrator will complete investigations and interviews for the next 3 incidents to provied an example of how througough complete investigation should be done. Training will be done with the QDDP's to show how to do a throuugh investigion by the facility administrator. Each QDDP will be required to complete a fake investiagion to show competency. We will be changing a procedure so the on call duities will be rotated so not just one person will soley be responsible for the investigaions. Checking the employee file will be added to the investigation checklist. QDDPs will be retrained on the policy of suspending staff immedially when there is an allegation of abuse or neglect. Competency will be determined via fake investigation role play. all investigations will be signed off by the facility administrator and executive diretor prior to event being closed. all completed by 9/23/20	

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W 127	Continued From page 4 from door. But did not think DSS-X was abusive but could be gentler when turning him. -Interview with HHD-Q (former HHD) at North Oak who stated when DSS-X was impatient or frustrated with C20 she would offer to give her a break, she had counseled DSS-X about yelling at C20 in the past. She further indicated she would not schedule DSS-X for multiple days in a row to prevent burn-out because C20 can be challenging/exhausting. A facility e-mail sent from QDDP-B to DSS-X, QDDP-R and director of oak creek services indicated, "An allegation was made that you verbally threatened a client. The internal review of this allegation is inconclusive and allegation was not sustain/proven. You are able to report to work as scheduled on Monday 7/20/20. I want to meet with you Monday morning to discuss recommendations I have made as a result of the internal review." During observation 7/22/20, at 10:00 a.m. C20 was walking around in North Oak house. DSS-X was following him around going from room to room with him. During interview 7/22/20, at 10:15 a.m. the facility administrator stated DSS-J had received training in reporting and should have immediately reported this incident to us (DSS-J no longer worked at the facility). In addition, after reviewing internal investigation notes, she stated while interviewing, QDDP-B should have asked staff more questions when they stated DSS-X had yelled, named called or was being rough to find out more information. Further more, she stated QDDP-B had received training in the past about keeping a open mind in his decisions while doing	W 127		

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W 127	Continued From page 5 his investigation and even though QDDP-R was the only one who received the interview from DSS-J about the allegation that should be enough. The administrator stated she will be following up with QDDP-B. Review of DSS-X employee file indicated the following: - Employee Disciplinary Report (EDR) dated 5/17/12, indicated DSS-X had improper conduct and violation of policy and procedures. The report indicated it was written warning. The report further indicated DSS-X was making abusive, hostile comments and directives to other staff and students (Laura Baker school with clients that attended). -EDR dated 7/20/20, indicated incident 7/13/20, inappropriate interactions with clients. "During an internal review of an allegation, several persons indicated [DSS-X] may be exhausted and/or frustrated with client behavior and responded by yelling or using language that is contrary to treating clients with respect." The EDR indicated it was a written warning and consequence would be discipline up to and including termination signed by QDDP-B and DSS-X on 7/21/20. QDDP-B's interval investigation was determined to be inconclusive despite having interviews from several interviews from staff stating she was loud, could be rough and was name calling, Furthermore, QDDP-B failed to asked additional questions of the staff when information was provided regarding potential rough handling and verbal abuse of clients by DSS-X. In addition, DSS-X was allowed to return to work and work directly with C20 on 7/21/20 without	W 127		

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W 127	Continued From page 6 adequate retraining of the abuse policy and procedure, without supervision and monitoring of her performance and interaction with clients and without adequate monitoring or enforcement of recommendation to ensure DSS-X was not be allowed to work excessive hours with C2. During interview 7/22/20, at 10:30 a.m. the director of oak services confirmed DSS-X was receiving training on vulnerable adult abuse and neglect policies today and a monitoring system was developed by management to ensure adequate oversight of her work hours and interacations with C20. The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 5/7/2020, indicated any employee or volunteer who has reason to believe a vulnerable adult or minor is being or has been maltreated must report it immediately. When the mandated reporter has reason to believe a report needs to be made, he/she must ensure clients are safe and have appropriate supervision. In addition the report indicated the program's mandated reporter or designee shall be responsible for reviewing and investigating the report, and directing or taking any and all actions to insure the safety of the vulnerable person, including, as appropriate, removing the alleged perpetrator from direct contact with the alleged victim.	W 127		
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	W 153	see above	

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(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 7 officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately contact the administrator and state agency for 1 of 1 clients (C20) alleged to have been verbally abused. Findings include: C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980 with a diagnosis of profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal. C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff. A Common Entry Report (CEP) dated 7/13/20, reported by qualified developmental disability professional (QDDP)-R, indicated "On Monday, July 13th, the household director where [C20] lives notified QDDP, that a previous staff (DSS-J) had reported some verbal threats directed towards [C20] from another staff person. The	W 153	All investiagations for the past 90 days will be reviewed to ensure appropriate documentation and immediately reported to state agency. QDDP's will be trained by the facility administrator on the facilities policy of reporting to MAARC immediatly when a maltreatment alligation is reported. All investigations are reviewed by the executive director and facility administrator within 3 days.	9/23/20

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 07/23/2020

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W 153	Continued From page 8 person reporting said that she heard direct support staff [DSS-X] threaten to "break [C20]'s teeth" or "break [C20]'s fingers." The person reporting said that during the incident, [C20] bit [DSS-X] and [DSS-X] told [C20] if he kept doing that she would "break his teeth". The report further went on to indicate C20 kept pointing at DSS-X and poking at her and she told him if he kept doing that she would break his fingers. A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and no staff could confirm any threats to C20. Lastly this report indicted it was closed by the facility administrator on 7/17/20. The report did not indicate what QDDP-B's conclusion was but was signed by the administrator. During interview 7/21/20 at 9:30 a.m. with QDDP-R who stated she was informed of the all allegation and called DSS-J to see it was true and she said yes and stated she did not report the incident to the state or the facility administrator. QDDP-R stated DSS-J was unsure the exact date but QDDP-R knew she started after COVID so it was sometime after March 2020 and she only worked here just a few months. QDDP-R then notified QDDP-B of the incident who notified the administrator.	W 153		

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W 153	Continued From page 9 The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 5/7/2020, indicated any employee or volunteer who has reason to believe a vulnerable adult or minor is being or has been maltreated must report it immediately and ensure clients are safe and have appropriate supervision. In addition the policy indicated the administrator must be notified.	W 153		
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 allegations of abuse for 1 of 1 client (C20) reviewed for staff to client abuse. Findings include: C20's Emergency Data Form (EDF) dated 7/21/20, indicated he admitted on 7/11/1980 with a diagnosis of profound intellectual disability, anxiety and panic attacks. In addition the form indicated he was non-verbal. C20's Individual Abuse Prevention Plan (IAPP) dated 2/26/20, indicated he would not remove himself from a abusive situation, and has 1:1 staff during all waking hours with the exception of 10 p.m. to 6:30 a.m. and redirect from abusive situations. All staff are trained to monitor for abuse and will follow the internal reporting	W 154	All reports will be reviewed for the past 90 days to assure thorough investigation has been completed QDDP's will be trained by the facility administrator on performing throughogh investigations, QDDPs will perform a "fake" investigation to determine competency. All investigations are reviewed by the executive director and facility administrator within 3 days.	9/23/20

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W 154	Continued From page 10 procedure. Further the IAPP indicated his 1:1 staff will be rotated per shift. Lastly the IAPP indicated he does not acknowledge needing to remove himself from a area of physically or verbally aggressive person thus needs 1:1 with staff. A Common Entry Report (CEP) dated 7/13/20, reported by qualified developmental disability professional (QDDP)-R, indicated "On Monday, July 13th, the household director where [C20] lives notified QDDP, that a previous staff (DSS-J) had reported some verbal threats directed towards [C20] from another staff person. The person reporting said that she heard direct support staff [DSS-X] threaten to "break [C20]'s teeth" or "break [C20]'s fingers." The person reporting said that during the incident, [C20] bit [DSS-X] and [DSS-X] told [C20] if he kept doing that she would "break his teeth". The report further went on to indicate C20 kept pointing at DSS-X and poking at her and she told him if he kept doing that she would break his fingers. A General Events Resolution (GER) dated 7/17/20, indicated QDDP-R contacted DSS-J (the previous staff) and she stated DSS-X threatened C20 and she did not report this because she did not feel DSS-X would follow through with it. QDDP-B (facility program mandated reporter) attempted to contact DSS-J multiple times to confirm the allegations and she did not answer her phone or reply to voice mails. Furthermore the report indicated by QDDP-B an attempt was made to contact all staff who worked with DSS-X in the last 30 days and staff who are employees could not confirm any threats to C20. Lastly this report indicted it was closed by the facility administrator on 7/17/20. The report did not	W 154	see above	

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W 154	Continued From page 11 indicate what QDDP-B's conclusion was but the report was signed by the administrator. During interview 7/21/20 at 1:00 p.m. QDDP-B stated he felt the report was inconclusive because he did not have any problems with DSS-X and had no disciplinary actions in her employee file when he looked today. He further stated he made multiple attempts to reach DSS-J and she did not return his calls even though QDDP-R told her he would be calling. DSS-X also denied the allegations. He then stated since he did hear back from DSS-J and had no concerns he felt the investigation was inconclusive. Furthermore QDDP-B stated he did not interview the other clients in the home and had no explanation as to why he did not include that as part of his process. An addition, the GER Resolution dated 7/16/20, at 1:29 p.m. last updated by the director of oak street services, indicated QDDP-B had several interviews dated 7/14/20 to 7/15/20 with no times, with staff which concluded the following: -Interview with HHD-P stated DSS-X has a loud and demanding voice. -Interview with DSS-Y stated she has heard DSS-X use some name calling such as "brat" and some rough handling such as turning C20 away from door. But did not this DSS-X was abusive but could be gentler when turning him. -Interview with DSS-X stated she has never threatened or told C20 she would harm him. -Interview with HHD-Q (former HHD)at North Oak who stated when DSS-X was impatient or frustrated with C20 she would offer to give her a break, she had counseled DSS-X about yelling at C20 in the past. She further indicated she would	W 154		

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W 154	Continued From page 12 not schedule DSS-X for multiple days in a row to prevent burn-out because C20 can be challenging/exhausting. Despite having several interviews from staff stating DSS-X was loud, could be rough with clients, and was observed calling clients names such as "brat", as well as gaining a history of previous concerns from her previous house supervisor of her direct behavior towards C20, QDDP-B's determination was inconclusive to abuse due to being unable to contact DSS-J himself (even though QDDP-R had already interviewed and received her report of the verbal abuse and physical threat made by DSS-X) and because there was not any history of concerns recorded in DSS-X's employee file. Further more QDDP-B failed to complete a thorough investigation when he did not inquire further regarding aggressive behavior reported during interviews gathered during the investigation and when QDDP-B failed to interview clients as part of the internal investigation. A facility policy revised 5/7/20, indicated 5. After reporting the incident of alleged abuse/neglect to the MAARC [Minnesota Adult Abuse Reporting Center] the programs mandated reporter will begin the internal investigation. The program reporter is responsible for using the checklists included in this policy for conducting a fair and impartial investigation. The internal review will also include an evaluation of whether related policies and procedures were followed and whether or not they were adequate, if there is a need for additional staff training. Further the policy indicated "If the report alleges abuse or neglect by a care giver, determine if the caregiver is a threat to the alleged victim or others."	W 154		

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Electronically Delivered Via Email November 12, 2020

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

RE: Event ID: X1CR12

Dear Administator:

On October 2, 2020, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with Conditions of Participation (CoP) pursuant to a fundamental survey, completed on July 23, 2020. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our PCR, we have determined that your facility has corrected Conditions of Participation (CoP) pursuant to our survey, completed on July 23, 2020.

The following Conditions of Participation (CoP) was found corrected at the time of the PCR:

W-0122 Client Protection 42 CFR 483.420

At the time of the revisit a deficiency was reissued.

W0153 - Staff Treatment of Clients

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).

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.

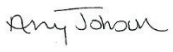
Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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, 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
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{W 000}	INITIAL COMMENTS An onsite revisit was completed on 9/30/20-10/2/20, by a surveyor of the Minnesota Department of Health to follow-up on the deficiencies issued during an abbreviated survey exited 7/23/20. The facility was NOT found to be in compliance with the requirements of 42 CFR 483. Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID.)	{W 000}		
{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 facility failed to ensure allegations of abuse were reported immediately within 2 hours to the administrator and state agency for 4 incidents involving 5 of 5 clients (C5, C6, C7, C8, C9) reviewed for abuse. Findings include: C5's Emergency Data Form (EDF) generated 10/1/20, indicated C5's diagnoses included severe intellectual disabilities, autistic disorder, attention deficit hyperactivity disorder, and convulsions. C5's Individual Abuse Prevention Plan (IAPP)	{W 153}		

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

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

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{W 153}	Continued From page 1	{W 153}		

dated 5/29/20, had an inability to identify potentially dangerous situations, was at risk for being abused and had the potential to abuse others by swearing, hitting or kicking others, and staff were to be present when not in his bedroom.

C5's Behavior Support Plan (BSP) dated 4/24/20, indicated C5's target behaviors included physical aggression toward others including hitting and kicking others and verbal aggression. C5's BSP included common triggers for behaviors and tips for avoiding target behaviors, including assisting with transitions by following a set routine.

C6's EDF generated 10/1/20, indicated C6's diagnoses included generalized anxiety disorder, intermittent explosive disorder, and profound intellectual disability.

C6's IAPP dated 11/29/19, indicated C6 was unable to identify potentially dangerous situations, was at risk for being abused and could display behaviors such as physical aggression and yelling, kicking, hitting, pulling hair or clothes to pull a person to the ground, which could be disruptive to other clients in the household. C6's behaviors were described and indicated staff or family was to be present at all times when she is not in her bedroom.

C6's Behavior Support Plan (BSP) dated 11/7/19, indicated C6's target behaviors included anxiety and physical aggression, with triggers that included times of transition, being told "no", and having too much to do. Several interventions were in place, including verbal redirection, informed of inappropriateness of her behavior. Tips to avoid target behaviors when each trigger occurred, were also included. C6 was noted to

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{W 153}	Continued From page 2	{W 153}		

become more aggressive when people were too close to her or invading her space, and interventions included staff to attempt to keep her peers out of her reach and place themselves between C6 and peers, especially during stressful transitions.

C7's EDF generated 10/2/20, indicated C7's diagnoses included a profound intellectual disability, anxiety disorder, attention deficit hyperactivity disorder, and panic disorder.

C7's IAPP dated 2/26/20, indicated C7 was at risk for being abused and had a history of being aggressive toward others by randomly hitting others, such as he passed them in hallways, or would hug them hard enough to slam the targeted individual into walls or knock them down. C7 was to have one-to-one staffing during all awake hours with the exception of 10 p.m. to 6:30 a.m., with staff to intervene and redirect to other activities, avoid congested areas, or areas with more people, and provide verbal redirection.

C7's Behavior Support Plan dated 2/27/18, used physical aggression such as hitting others or spitting at others in an attempt to communicate, usually when not feeling well, does not want to do something, or does not like something. C7's target behaviors included panic attacks, spitting, and physical aggression which can happen when upset or randomly. Staff were to provide one-to-one staff which was to avoid congested areas, block attempts to hit others, suggest time in his room.

C8's EDF generated 10/2/20, indicated C8's diagnoses included a moderate intellectual disability and intermittent explosive disorder.

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{W 153}	Continued From page 3	{W 153}		

C8's IAPP dated 7/27/20, indicated C8 was at risk for being abused and had a history of being physically and verbally aggressive to others. C8 was to have goals to work on decreasing inappropriate behaviors and was to be checked on every 15 minutes when alone in her room and awake, and every 60 minutes when sleeping.

C8's BSP target behaviors included aggression, such as hitting, kicking, hair pulling, throwing objects, or choking, and was on a reinforcement/reward system program. Interventions included redirection to a more appropriate activity without giving attention for aggression.

C9's EDF generated 10/2/20, indicated C9's diagnoses included a personality disorder, intermittent explosive disorder, and severe intellectual disability.

C9's IAPP dated 7/10/20, indicated C9 was at risk for being abused, and lacked understanding of appropriate boundaries and displayed behaviors such as hugging and kissing others. C9 was to be supervised at home and in the community and provide verbal redirection. C9 was to be checked on every 15 minutes when in his room and awake, and every hour when asleep. In addition, staff were to intervene when C9 was dealing with aggression from another person.

C9's BSP dated 7/10/20, indicated C9's target behaviors included physical aggression, with a trigger of frustration and not getting his way, and staff were to redirect C9 to another activity.

A Common Entry Point (CEP) report dated

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LAURA BAKER SERVICES ASSOCIATION	**211 OAK STREET NORTHFIELD, MN 55057**

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{W 153}	Continued From page 4 8/23/20, at 10:40 p.m., indicated an incident on 8/23/20, at 7:50 p.m. occurred when C8 grabbed and dug nails into C7's arm. A CEP dated 9/18/20, indicated an incident on 9/17/20, at approximately 3:20 p.m. occurred when C6 exited her bedroom, walked into the living room, turned and grabbed C5 by the shirt and pulled on him. C5 and C6 were separated and C5 left the area. The CEP indicated the incident was not reported until 9/18/20, at 11:15 a.m. by the qualified developmental disability professional (QDDP)-C. A General Event Reports (GER) for an incident dated 9/17/20, indicated at 3:20 p.m. C5 was grabbed by C6 and pulled off the sofa. C5 received several fingernail scratches on his neck when he was grabbed by his collar. The GER indicated QDDP-C was present and responded to the incident at the time of occurrence. QDDP-C documented on the GER, that the report was reviewed and reported to the state agency (SA) on 9/18/20, at 12:54 p.m. A CEP report dated 9/22/20, indicated an incident on 9/22/20, at approximately 10:30 a.m. occurred when C7 became upset with staff when a request was not fulfilled and C7 slapped C9 on the top of the head. C9 became upset, and staff moved C7 to a different sofa and stayed with him. The CEP indicated the incident was not reported until 9/22/20, at 1:50 p.m. by the QDDP-C. A GER dated 9/22/20, indicated C7 hit C9 on the head at 10:30 a.m. when C7 was upset when he was asked to wait for staff to assist him before going outside without shoes on.	{W 153}		

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 _____	R-C 10/02/2020

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

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{W 153}	Continued From page 5	{W 153}		

A CEP report dated 10/1/20, indicated an incident on 10/1/20, at approximately 4:50 p.m. occurred when C7 slapped C9 on the back as he walked by him. The CEP indicated the incident was not reported to the SA until 9:45 p.m.

A GER dated 10/1/20, indicated an incident on 10/1/20, at 4:30 p.m. C7 was walking down the hall and slapped C9 on the back as he walked by. Staff intervened to separate C7 and C9. The GER indicated QDDP-C, the facility mandated reporter, was not notified until 8:30 p.m.

On 10/2/20, at 10:51 a.m. qualified developmental disabilities professional (QDDP)-C stated when he has received the report of potential abuse allegations, he reported it as soon as possible, within 24 hours. QDDP-C stated he did not know he was to report within 2 hours. QDDP-C stated staff usually report to him when they did the incident report later in their shift. QDDP-C stated he was present during C6's aggression toward C5, and verified he did not report it until the next day. QDDP-C stated he thought it was reported within the guidelines.

On 10/2/20, at 11:11 a.m. QDDP-UU stated QDDP-C was the mandated reporter for the facility, so he would be the one to make the notifications to the SA, but QDDP-UU stated she has done some reports to the SA also. QDDP-UU stated the report to the SA would be done immediately, as soon as possible.

On 10/2/20, at 11:46 a.m. director of facility services (DOS)-TT at this location, verified potential abuse allegations should be reported immediately from staff to administrator, as soon as it safe to do so. DOS-TT stated the abuse

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 _____	R-C 10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{W 153}	Continued From page 6 allegation should then be reported immediately to the state agency. DOS-TT stated they had trained staff to report right away and not to wait until the end of the shift. The facility Policy & Procedures for the Prevention & Reporting of Individual Maltreatment revised 5/7/2020, indicated any employee or volunteer who has reason to believe a vulnerable adult or minor is being or has been maltreated must report it immediately and ensure clients are safe and have appropriate supervision. In addition the policy indicated the administrator must be notified.	{W 153}		