



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

November 10, 2022

Administrator
Lake Owasso Residence
210 Owasso Blvd North
Shoreview, MN 55126

RE: Event ID: 6HD111

Dear Administrator:

On November 2, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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 survey, the survey team noted one or more deficiencies.

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

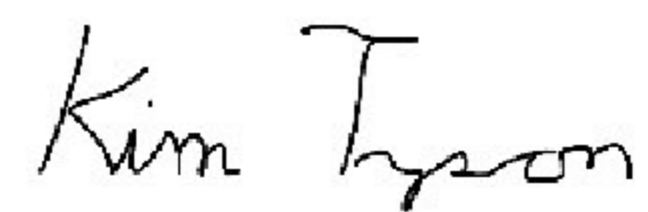
Lake Owasso Residence

Sarah Grebenc, Unit Supervisor
Metro A District Office
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
Email: sarah.grebenc@state.mn.us
Phone: Mobile (651)238-8786

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,

A handwritten signature in black ink that reads "Kim Tyson". The signature is written in a cursive, slightly slanted style.

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

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

PRINTED: 11/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G208	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/02/2022
NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126		
(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	<p>INITIAL COMMENTS</p> <p>On 11/2/22, an abbreviated survey was completed at your facility to conduct a compliance investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.</p> <p>The following complaints were found to be SUBSTANTIATED with no deficiencies issued HG2085558C (MN88095/MN88096), HG2085530C (MN87287),</p> <p>The following complaints were found to be UNSUBSTANTIATED with no deficiencies issued. HG2085531C (MN85973), HG2085471C (MN88065),</p> <p>However, as a result of the investigation, a deficiency was cited at W153</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	W 000	<p>Sarah Grebenc</p> <p>Digitally signed by Sarah Grebenc Date: 2022.11.23 15:45:49 -06'00'</p> <p>Based on this area of concern, the following plan of correction will be instituted with a completion date of 12/5/22:</p> <p>Services Program Director will provide training to all Program Supervisors on Lake Owasso Policy of reporting all incidents to the Administrator or designee immediately after an incident occurs or becomes known to staff, including injuries of unknown origin not easily explainable by known risk factors. "Immediately" means as soon as possible after a situation has been stabilized and resident safety assured.</p> <p>Program Supervisors will train their assigned staff after completing the training with all staff trained by 12/5/22.</p>	12/5/22
W 153	<p>STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of injury of unknown origin to designated State</p>	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Kevin Thompson, Administrator

TITLE

(X6) DATE
11/22/22

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	<p>Continued From page 1</p> <p>Agency (SA) for 1 of 1 client (C3) reviewed during a complaint investigation.</p> <p>Findings include:</p> <p>The facility's Internal Investigation Report dated 10/28/22, indicated C3 had Epilepsy, Autism, and Severe Intellectual Disability. The report also indicated C3 was functionally non verbal, and not able to verbally express feelings or thoughts, and "both the VA and AP have had physical aggressions between the two of them. Historically they both have been subject to being the VA or the AP in incidents."</p> <p>During interview on 11/2/22, at 11:45 a.m. program director (PD)-A stated he was informed by C3's parent in an email sent on 10/27/22 at around 7:30 p.m., regarding a "mark" on C3's upper left thigh. PD-A indicated as soon as he read the email on 10/28/22, he started an investigation, and reported per facility policy. He indicated all staff receive abuse training yearly.</p> <p>During interview on 11/2/22, at 3:06 p.m., residential counselor (RC) - A stated he did work with C3 on 10/27/22. He indicated he came to work at 8:00 a.m. and was scheduled as C3's one on one for the day. At 8:15 a.m. he assisted C3 in the bathroom. C3 removed his pants and RC-1 noticed a round red mark on C3's left upper thigh. The skin was not broken. RC-1 indicated after assisting C3 in the bathroom, he asked his co workers if they knew about the red area, and he was informed C3 triad to grab C4's ball while C4 was sitting at the couch, and the staff intervened. RC-A indicated nursing was notified and the nurse indicated someone had to complete a report. RC-A indicated later in the day</p>	W 153		

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W 153	<p>Continued From page 2</p> <p>he noticed the red area on C3's thigh was more distinct and "looked like teeth marks" . RC-A indicated he told C3's parent when C3 was picked up around 3 p.m. RC-A indicated he did not think he had to fill out a report or report it to his supervisor as he was not the staff that observed the incident. During questioning about reporting, RC-A thought the staff who witnessed a incident is responsible for reporting it. When questioned on an injury of unknown origin, RC-A indicated PD-A did talk to him about it on 10/28/22, and he should have reported it, but he did not witness any altercation with C3. RC-A indicated he received training on reporting, vulnerable adult and abuse every year from the facility.</p> <p>During interview on 11/2/22, at 3:30 p.m., PD-A indicated RC-A was reeducated on reporting, especially injuries of unknown origin on 10/28/22, PD-A indicated more education will be give to all staff especially about injuries of unknown origin.</p> <p>Facility Policy Reporting of Maltreatment of Vulnerable Adults dated 9/30/22, indicated "All mandated reporters will report suspected allegations of abuse, neglect, maltreatment, or mistreatment, injuries of unknown origin source, exploitation, involuntary seclusion, and misappropriation of property to the administrator or designee immediately." In addition the policy indicated the facilities operations program director or administrator will assume responsibility for assessing if the report must be forwarded to the MAARC.</p> <p>The policy also indicated "injury of unknown source" is when:</p> <ul style="list-style-type: none"> · the source of the injury was not witnessed by any person; 	W 153		

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W 153	Continued From page 3 · the source of the injury could not be explained by the resident; and · the injury raises suspicions of possible abuse or neglect because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries.	W 153			



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November 10, 2022

Administrator
Lake Owasso Residence
210 Owasso Blvd North
Shoreview, MN 55126

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: 6HD111

Dear Administrator:

The above facility was surveyed on November 2, 2022 through November 2, 2022 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 one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

The first page of the state orders should be signed and submitted along with your federal plan of correction to:

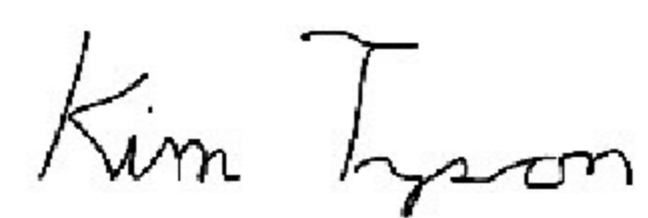
Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Phone: Mobile (651)238-8786

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Sarah Grebenc. A written plan for correction of licensing orders is not required.

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.

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

Sincerely,



Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/02/2022
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NAME OF PROVIDER OR SUPPLIER LAKE OWASSO RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 OWASSO BLVD NORTH SHOREVIEW, MN 55126
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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. On 11/2/22, a complaint investigation was conducted. Your facility was found to be not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).</p> <p>The following complaints were found to be SUBSTANTIATED with no deficiencies issued HG2085558C (MN88095/MN88096), HG2085530C (MN87287),</p>	5 000		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kevin Thompson, Administrator	TITLE 	(X6) DATE 11/22/22
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Minnesota Department of Health

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5 000	Continued From page 1 The following complaints were found to be UNSUBSTANTIATED with no deficiencies issued. HG2085531C (MN85973), HG2085471C (MN88065), However, as a result of the investigation, related licensing orders were issued.	5 000		
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (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: (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 (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). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (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. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement	5 815		

Minnesota Department of Health

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5 815	<p>Continued From page 2</p> <p>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 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 immediately report allegations of injury of unknown origin to designated State Agency (SA) for 1 of 1 client (C3) reviewed during a complaint investigation.</p> <p>Findings include:</p> <p>The facility's Internal Investigation Report dated 10/28/22 , indicated C3 had Epilepsy, Autism, and Severe Intellectual Disability. The report also indicated C3 was functionally non verbal, and not able to verbally express feelings or thoughts, and "both the VA and AP have had physical aggressions between the two of them. Historically they both have been subject to being the VA or the AP in incidents."</p>	5 815		

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5 815	<p>Continued From page 3</p> <p>During interview on 11/2/22, at 11:45 a.m. program director (PD)-A stated he was informed by C3's parent in an email sent on 10/27/22 at around 7:30 p.m., regarding a "mark" on C3's upper left thigh. PD-A indicated as soon as he read the email on 10/28/22, he started an investigation, and reported per facility policy. He indicated all staff receive abuse training yearly.</p> <p>During interview on 11/2/22 at 3:06 p.m., residential counselor (RC) - A stated he did work with C3 on 10/27/22. He indicated he came to work at 8:00 a.m. and was scheduled as C3's one on one for the day. At 8:15 a.m. he assisted C3 in the bathroom. C3 removed his pants and RC-1 noticed a round red mark on C3's left upper thigh. The skin was not broken. RC-1 indicated after assisting C3 in the bathroom, he asked his co workers if they knew about the red area, and he was informed C3 triad to grab C4's ball while C4 was sitting at the couch, and the staff intervened. RC-A indicated nursing was notified and the nurse indicated someone had to complete a report. RC-A indicated later in the day he noticed the red area on C3's thigh was more distinct and "looked like teeth marks". RC-A indicated he told C3's parent when C3 was picked up around 3 p.m. RC-A indicated he did not think he had to fill out a report or report it to his supervisor as he was not the staff that observed the incident. During questioning about reporting, RC-A thought the staff who witnessed a incident is responsible for reporting it. When questioned on an injury of unknown origin, RC-A indicated PD-A did talk to him about it on 10/28/22, and he should have reported it, but he did not witness any altercation with C3. RC-A indicated he received training on reporting, vulnerable adult and abuse every year from the facility.</p>	5 815		

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5 815	<p>Continued From page 4</p> <p>During interview on 11/2/22 at 3:30 p.m., PD-A indicated RC-A was reeducated on reporting, especially injuries of unknown origin on 10/28/22, PD-A indicated more education will be give to all staff especially about injuries of unknown origin.</p> <p>Facility Policy Reporting of Maltreatment of Vulnerable Adults dated 9/30/22, indicated "All mandated reporters will report suspected allegations of abuse, neglect, maltreatment, or mistreatment, injuries of unknown origin source, exploitation, involuntary seclusion, and misappropriation of property to the administrator or designee immediately." In addition the policy indicated the facilities operations program director or administrator will assume responsibility for assessing if the report must be forwarded to the MAARC.</p> <p>The policy also indicated "injury of unknown source" is when:</p> <ul style="list-style-type: none"> · the source of the injury was not witnessed by any person; · the source of the injury could not be explained by the resident; and · the injury raises suspicions of possible abuse or neglect because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries. <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	5 815		