Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

January 9, 2024

Administrator
Axis On White Bear Avenue
3516 White Bear Avenue
White Bear Lake, MN 55110

RE: Event ID: NUYC12

Dear Administrator:

On December 27, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

January 9, 2024

Administrator
Axis On White Bear Avenue
3516 White Bear Avenue
White Bear Lake, MN 55110

Re: Enclosed Re-inspection Results - Event ID: NUYC12

Dear Administrator:

On December 27, 2023 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a re-inspection of your facility, to determine correction of orders found on the survey completed on November 29, 2023. At this time these correction orders were found corrected.

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

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

December 7, 2023

Administrator
Axis On White Bear Avenue
3516 White Bear Avenue
White Bear Lake, MN 55110

RE: Event ID: NUYC11

Dear Administrator:

On November 29, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. This survey found one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the survey we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the electronically delivered "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy effective November 29, 2023.

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):

W122 42 CFR § 483.420 – Client Protections

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.

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

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:

Susie Haben, Rapid Response
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

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 **January 23, 2024**, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

December 7, 2023

Administrator
Axis On White Bear Avenue
3516 White Bear Avenue
White Bear Lake, MN 55110

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: NUYC11

Dear Administrator:

The above facility was surveyed on November 17, 2023 through November 29, 2023 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:

Susie Haben, Rapid Response
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

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 Susie Haben. 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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22847	A. BUILDING: _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIS ON WHITE BEAR AVENUE	3516 WHITE BEAR AVENUE WHITE BEAR LAKE, MN 55110

(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 11/17/23, 11/21/23-11/22/23, 11/28/23-11/29/23 , a standard abbreviated survey was conducted. Your facility was found to be not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaints were reviewed. HG5057131C MN98137 HG5053263C MN94717 HG5057311C MN92628	5 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G505	A. BUILDING _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 000	INITIAL COMMENTS received 12/15/23 approved 12/22/23 POC 12/22/23 Susie Haben On 11/17/23, 11/21/23-11/22/23, 11/28/23-11/29/23, a standard abbreviated survey was completed at your facility to conduct a complaint(s) investigation. Your facility was NOT in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following complaints were reviewed. HG5057131C MN98137 HG5053263C MN94717 HG5057311C MN92628 HG5057204C MN98452 with a deficiency issued at W150. The Condition of Client Protections 42 CFR 483.420 was not found to be met at W122. The IJ began on 11/9/23 at approximately 5:00 p.m. when the facility failed to protect C1 from ongoing abuse when, after C1 reported an allegation of staff to client abuse, the facility failed to remove the alleged perpetrator (AP) from the working shift, continued to allow the AP to work with vulnerable adults during the investigation, and failed to substantiate the allegation despite having witnesses and video footage. Lastly, the facility allowed the AP to return to work without any education or discipline. The administrator was notified of the IJ on 11/22/23 at 4:20 p.m. and the IJ was removed on 11/29/23 at 12:07 p.m. when the facility's approved removal plan was verified onsite by the state agency. In addition, deficiencies were issued at W149, W153 and W154.	W 000	W 122 Plan for correcting the deficiency • Axis policy "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" has been revised to include the following statement, "Any time during the investigation for allegations of abuse against employees, those employees will be removed from care of vulnerable adults immediately and ongoing pending the results of the investigation. • The Directors of Program Services, Director of Nursing, Program Supervisors, Program Staff, and Managers On Call have been trained on the revised procedure. Please see attached. Procedure for implementing the POC • The Chief Operations Officer has trained the Directors of Program Services and the Director of Nursing on the revised policy. • The Director of Program Services has trained the Program Supervisors, Program Staff, and Managers On Call on the revised procedure. • Program staff who are LOA will be retrained on the procedure upon their return Monitoring the POC • Program Supervisors and Managers On Call will ensure the "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" is adhered to. Title of the person responsible for the POC • Chief Operations Officer • Director of Program Services Date by which the plan will be completed. o 12/8/2023	

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

Mark Roberts — Director of Program Services — 12/15/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G505	A. BUILDING _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIS ON WHITE BEAR AVENUE	3516 WHITE BEAR AVENUE WHITE BEAR LAKE, MN 55110

(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	Continued From page 1 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.	W 000	W 149 Plan for correcting the deficiency • Axis policy "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" has been revised to include the following statement, "Any time during the investigation for allegations of abuse against employees, those employees will be removed from care of vulnerable adults immediately and ongoing pending the results of the investigation." o The Directors of Program Services, Director of Nursing, Program Supervisors, Program Staff, and Managers On Call have been trained on the revised procedure. Please see attached. • The "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" states: "All knowledge of and written information about alleged or suspected abuse, neglect, financial exploitation, injury of unknown origin of a client, or, physical aggression of one client to another client served by Axis, will be reported immediately by the mandated reporter, by one of the following methods: 1) make an internal report by completing the First Report of Incident Form and communicating this to the designated nurse (primary contact person) and administrator immediately, and make an oral report immediately to the Minnesota Adult Abuse Reporting Center, or; 2) will make an external oral or online report directly to the Minnesota Adult Abuse Reporting Center (MAARC) immediately and to the Axis Administrator immediately. o The Directors of Program Services, Director of Nursing, Program Supervisors, Program Staff, and Managers On Call have been retrained on the procedure. Please see attached.	
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on observation, interview and document review the facility was found not to be in compliance with 42 CFR 483.420 the Condition of Participation of Client Protection due to the facility's failure to to protect 1 of 3 clients (C1), who was reviewed for abuse. Findings include: See W150: Based on observation, interview and document reviewed, the facility failed protect 1 of 3 clients (C1), who alleged abuse from staff which resulted in an immediate jeopardy (IJ) for C1.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to implement abuse policies and procedures consistent with federal regulations by not reporting to the State Agency (SA) immediately and not removing AP from the work schedule for an alleged client abuse for 1 of 1 client (C1) reviewed for abuse.	W 149		

(continued page 3 of 17)

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 149	Continued From page 2 Findings include: C1's profile, undated, indicated diagnoses included mild intellectual disability, anxiety disorder, and borderline personality disorder. Facility incident report dated 11/9/23 at 5:00 p.m., indicated staff forgot C1 planed to attend a family event after work. C1 swore profanities and threw pictures frames around the house. C1 claimed staff hit them, however, there were no markings. On-call supervisor received a call from direct support personnel (DSP)-A and DSP-A was "screaming at C1 in the background in his attempts to de-escalate". Facility failed to report incident of alleged abuse to the SA immediately, report filed with SA on 11/10/23 at 10:20 a.m. Facility internal reporting and investigation lacked implementing action plan of re-educating DSP-A and removing DSP-A from working schedule during the investigation. Facility concluded no abuse occurred but rather DSP-A was "loud" but at their normal tone of voice and demeanor. Investigation also lacked including camera footage which was provided later in the investigation. During phone call interview on 11/21/23 at 12:49 p.m., on-call supervisor (OCS) confirmed he met with C1 at the facility due to a "mental health crisis". OCS stated a call was received by DSP-A and "he was yelling at C1 over the phone" and there was no attempt to de-escalating the situation made by DSP-A. OCS arrived at the facility and met with C1 in her room and C1 requested to not have DSP-A work with her as she was scared. OCS stated DSP-A was not sent home and did work the rest of his shift which	W 149	Procedure for implementing the POC • The Chief Operations Officer has trained the Directors of Program Services and the Director of Nursing on the policy revisions to the "Vulnerable Adults Maltreatment Reporting and Internal Review Policy". o The Director of Program Services has trained the Program Supervisors, Program Staff, and Managers On Call on the revised policy. o Program staff who are on LOA will be retrained on procedure upon their return. • The Chief Operations Officer has retrained the Directors of Program Services and the Director of Nursing on reporting immediately to the MAARC as outlined in the "Vulnerable Adults Maltreatment Reporting and Internal Review Policy". o The Director of Program Services has retrained the Program Supervisors, Program Staff, and Managers On Call on reporting immediately to the MAARC as outlined in the "Vulnerable Adults Maltreatment Reporting and Internal Review Policy". Monitoring the POC • Program Supervisors and Managers On Call will ensure the "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" is adhered to. Title of the person responsible for the POC • Chief Operations Officer • Director of Program Services Date by which the plan will be completed. o 12/8/2023	

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W 149	Continued From page 3 included 3 hours of working alone. OCS stated DSP-A did not work with C1, however, was allowed to work at other facility locations with vulnerable adults. OCS confirmed a report to the SA was late. OCS stated "I thought it was 24 hours to report." During interview on 11/22/23 at 12:39 p.m., director of program services (DPS) confirmed the investigation of the incident on 11/9/23 was lead by her. DPS completed the interview with DSP-A and DSP-B and concluded there was no harm physically or verbally to C1 but "missed following protocol and was not professional". DPS stated DSP-A was not suspended during the investigation and "we missed that". DPS confirmed the camera footage was not part of the investigation but did review it and not all witnesses were interviewed. DPS stated plan of correction was to re-educate DSP-A and to plan to give him a warning however had not been completed. Facility policy titled "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" dated 6/26/15 indicated all individuals will be cared for with respect and will be protected from any abuse, neglect or exploitation. Upon receiving the initial report of the incident the primary contact Director of Program Services shall immediately initiate internal investigative procedures. Investigating procedures shall include but not be limited to: physical examination, written report regarding injuries, interviews with the person reporting the incident and any witnesses to the incident, written reports by all persons involved, interview with the perpetrator of the allegation, records of any previous abuse and update and provide final	W 149		

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W 149	Continued From page 4 reports to the Director of Program Services as soon as possible. Any time during the investigation, the alleged perpetrator may be dismissed from work pending further investigation. Upon completion of the internal investigation, a conclusion will be made and appropriate disciplinary actions may be imposed upon the employee.	W 149		
W 150	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1)(i) Staff of the facility must not use 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 1 of 1 client (C1) from staff abuse when direct support professional (DSP)-A had an allegation of verbal abuse towards C1. This resulted in an Immediate Jeopardy (IJ). The IJ began on 11/9/23 at approximately 5:00 p.m. after C1 reported an allegation of staff to client abuse and the facility failed to protect the client and other clients from further potential abuse by not removing the alleged perpetrator (DSP-A) from the working shift and shifts during the investigation. The administrator was notified of the IJ on 11/22/23 at 4:20 p.m. and the IJ was removed on 11/29/23 at 12:07 p.m. when the facility's approved removal plan was verified onsite by the state agency. Findings include: C1's profile, undated, indicated C1 diagnoses were mild intellectual disability, anxiety disorder and borderline personality disorder.	W 150		

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 150	Continued From page 5 C1's Behavior Support Plan, Manage Anxiety dated 9/18/23, indicated C1 had a history of anxiety. C1 will obsess over different topics including health issues, outings, appointments, something they feel needs to be fixed. C1 struggles to independently find ways to lessen their anxiety on their own. With cues from staff, C1 had listened to music, initiated going outside and sitting on the swing or on the deck to relax. If C1 is obsessing about a particular topic for more than 10 minutes and was not happy with the answers staff will suggested C1 use her coping strategies in order to assist C1 to calm down. Staff will give C1 choice of coloring, puzzle books or music, deep breathing, or watching TV. If C1 is being verbally or appeared to become physically aggressive or say hurtful things toward staff, staff are not to respond/react to what she is saying and move out of range of C1 being able to aggress toward staff. Staff are not to argue with C1 or get into any sort of power struggle with C1. C1's Coordinated Services and Support Plan (CSSP) dated 2/1/23, indicated C1 needed care as a vulnerable adult. C1 needed to reside in a safe and protected environment, with a 24-hour plan of care delineating the provision of ongoing, daily care, supervision, monitoring, assistance, guidance, direction, training and support, in the least restrictive, most normative setting possible. Review of phone camera footage on 11/21/23 at 2:13 p.m., revealed C1 sitting in a chair in the living room, grabbing items from a cabinet and throwing them on the floor. C1 stated, in quiet tone, "I don't want to be here" two times. C1 then raised her voice and stated, "my sister said to leave me alone" and pointed at DSP-A. DSP-A	W 150	W 150 Plan for correcting the deficiency • DSP - A has been removed from the schedule and will no longer be working vulnerable adults through Axis Minnesota, Inc. • Axis policy "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" has been revised to include the following statement, "Any time during the investigation for allegations of abuse against employees, those employees will be removed from care of vulnerable adults immediately and ongoing pending the results of the investigation." o The Directors of Program Services, Director of Nursing, Program Supervisors, Program Staff, and Managers On Call have been trained on the revised procedure. Please see attached. Procedure for implementing the POC • The Chief Operations Officer has trained the Directors of Program Services and the Director of Nursing on the policy revisions to the "Vulnerable Adults Maltreatment Reporting and Internal Review Policy". o The Director of Program Services has trained the Program Supervisors, Program Staff, and Managers On Call on the revised policy. o Program staff who are on LOA will be trained on the procedure upon their return. (Continued Page 6 of 17)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AXIS ON WHITE BEAR AVENUE	3516 WHITE BEAR AVENUE WHITE BEAR LAKE, MN 55110

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W 150	Continued From page 6 then moved toward C1 and yelled in a loud and aggressive tone, "I hope you fall". C1 then yelled back, "fuck you [DSP-A]". C1 then stated quietly, "I'm not scared [DSP-A]". Footage then ended. Observation on 11/21/23 at 4:02 p.m., C1 was in living room with other clients and staff. There was no verbal or physical interaction between C1 and DSP-A. C1 was social with other clients and other staff present. Facility incident report dated 11/9/23 at 5:00 p.m., indicated staff forgot C1 plans after work to attend a family event. C1 swore profanities and threw pictures frames around the house. C1 claimed staff hit her, there were no markings. On-call supervisor received a call from DSP-B and DSP-A was "screaming at C1 in the background in his attempts to de-escalate". Facility incident report revealed DPS-A was screaming at C1, which was specifically identified as ineffective in C1's behavioral care planning as well as supportive to the allegation of abuse. During interview on 11/17/23, at 3:56 p.m., C1 stated she was upset because she missed her ride to see her family. C1 stated DSP-A was yelling at her and telling her to go to her room and calm down. C1 recalled feeling scared, sad and wanted to run away from the facility. During interview, C1 was speaking in a quiet tone and stated she was worried if DSP-A heard what she was saying about him, he would yell at C1 again. C1 demonstrated her bedroom door was locked while she was in her room or outside of her room to be safe from DSP-A. During phone interview on 11/21/23, at 12:44	W 150	Monitoring the POC • Program Supervisors and Managers On Call will ensure the "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" is adhered to by removing employees from care of vulnerable adults immediately and on ongoing pending the results of the investigation." • The Director of Programs Services upon knowledge of an allegation abuse will ensure the policy was followed as written. Title of the person responsible for the POC • Director of Program Services Date by which the plan will be completed. o 12/8/2023	

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	24G505	A. BUILDING _____ B. WING _____	C 11/29/2023

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W 150	Continued From page 7 p.m., FM-A indicated they were visiting another client in the home on 11/9/23 and observed C1 in distress and asking to leave. FM-A stated, during the incident, they stayed in the other client's room but heard a lot of yelling from many different people. During phone interview on 11/21/23 at 12:19 p.m., direct support professional (DSP)-B stated they were present during incident on 11/9/23 and recalled C1 being upset when coming home from work. DSP-B indicated DSP-A sent C1 to her room to calm down which was not effective. DSP-B stated when C1 was being destructive of property, staff were to stay calm to help C1 calm down. DSP-B stated DSP-A normally talks loud and did not change his voice when attempting to de-escalate the situation with C1. DSP-B stated C1 did not calmed down until on-call supervisor was called and came to facility. DSP-B indicated the video footage was taken to in an attempt to record C1's destructive behavior. During phone call interview on 11/21/23 at 12:49 p.m., on-call supervisor (OCS) confirmed he met with C1 at the facility due to a "mental health crisis". OCS stated a call was received by DSP-A and "he was yelling at C1 over the phone" and there was no attempt to de-escalating the situation made by DSP-A. OCS arrived at the facility and met with C1 in her room and C1 requested to not have DSP-A work with her as she was scared. OCS stated DSP-A was not sent home and did work the rest of his shift which included 3 hours of working alone. OCS stated DSP-A did not work with C1 however was allowed to work at other facility locations with vulnerable adults following that shift and during the investigation.	W 150		

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W 150	Continued From page 8 During phone call interview on 11/21/23 at 1:24 p.m., C1's guardian/family (FM-B) stated a phone call was placed to the facility to find out why C1 did not come to the family event. FM-B stated, "I called the facility and [DSP-A] was screaming on the phone and telling guardian he didn't know [C1] was supposed to go and just kept screaming". FM-B further stated, "I tried to correct [DSP-A] and told him stop like three times to take your voice down and he did not listen and [C1] was also crying hysterically loud enough to be heard through the phone." FM-B stated a supervisor was called and when they arrived OCS informed the FM-B of concerns they had. FM-B indicated they thought OCS was going to send DSP-A home but didn't because she called again later and DSP-A was heard yelling again at C1 to pick something up off the floor. During interview on 11/21/23 at 2:45 p.m., DSP-A stated C1 was upset when she got home from work because she missed her ride to a family event. DSP-A confirmed he did not know she had special plans after work. DSP-A stated C1 was redirected to her room to "cool down" as C1 was screaming, calling staff names, grabbing things off the wall. DSP-A recalled being calm during the incident and called C1's FM-B in attempt to calm C1 as a de-escalation technique. DSP-A stated he continued to work after this incident and had received no education by the time of this interview. During interview on 11/21/23 at 3:09 p.m., qualified intellectual disability professional (QIDP) stated C1 was very social, has tons of questions and remembers details. QIDP stated C1 was interview by house supervisor and himself and	W 150		

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W 150	Continued From page 9 heard C1 story, got timelines and details of the incident. QIDP stated C1 did appear to be scared and teared up off and on during the interview. QIDP stated working with C1 it is crucial to be calm when C1 is escalating. QIDP revealed there had also been history with DSP-A with related concerns involving threatening to lock clients bedroom doors to keep them in common areas of the home and moving clients in a wheel chair "out of the way" and then locking their brakes to keep them from moving. During interview on 11/22/23 at 11:36 a.m., house supervisor (HS) stated C1 is normally a very social person but had noticed changes with C1 such as isolating in her room and locking her door, these are all new behaviors since incident. HS recalled being called via phone about C1 missing her ride and C1 being aggressive and upset. HS stated a plan was developed with on-call supervisor to go to the facility and address the concerns and de-escalate the situation. HS stated DSP-A did work the rest of his shift after this incident and was left alone for 3 hours. HS completed interview with C1 and she reported being scared of DSP-A and wanting to leave the facility to not be around DSP-A, this interview was shared with director of program services (DPS) who was leading the investigation. HS was not aware of any disciplinary action taken with DPS-A. During interview on 11/22/23 at 12:39 p.m., director of program services (DPS) confirmed she was the lead investigator for the 11/9/23 allegation of abuse. DPS indicated she completed the interview with DSP-A and DSP-B and concluded there was no harm physically or verbally to C1 but "missed following protocol and	W 150		

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W 150	Continued From page 10 was not professional". DPS stated DSP-A was not suspended during the investigation and "we missed that". DPS confirmed watching the available camera footage was not part of the investigation and not all witnesses were interviewed. DPS also indicated the facility did not substantiate the incident as abuse and the plan of correction was to re-educate DSP-A and to plan to give him a warning however nothing had been completed yet and DSP-A had already returned to work. DPS stated being aware of DSP-A recent employee write ups however was not aware of the most recent concern on 11/2/23. Facility policy titled "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" dated 6/26/15 indicated all individuals will be cared for with respect and will be protected from any abuse, neglect or exploitation. Upon receiving the initial report of the incident the primary contact Director of Program Services shall immediately initiate internal investigative procedures. Investigating procedures shall include but not be limited to: physical examination, written report regarding injuries, interviews with the person reporting the incident and any witnesses to the incident, written reports by all persons involved, interview with the perpetrator of the allegation, records of any previous abuse and update and provide final reports to the Director of Program Services as soon as possible. Any time during the investigation, the alleged perpetrator may be dismissed from work pending further investigation. Upon completion of the internal investigation, a conclusion will be made and appropriate disciplinary actions may be imposed upon the employee.	W 150		

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W 150	Continued From page 11 The immediate jeopardy that began on 11/9/23, was removed on 11/29/23 at 12:07 p.m. when it was verified the facility implemented the following: - DSP-A was removed from the schedule and was no longer working with vulnerable adults through Axis Minnesota, Inc. - The Vulnerable Adults Maltreatment Reporting and Internal Review Policy was reviewed and revised by the Directors of Program Services to ensure it was in line with regulatory requirements. - All direct support professionals and supervisors/leaders were retrained on the Vulnerable Adults Maltreatment Reporting and Internal Review Policy prior to the next time they were scheduled to work to ensure all policies would be implemented appropriately.	W 150	W 153 Plan for correcting the deficiency • Axis policy "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" has been revised to include the following statement, "Any time during the investigation for allegations of abuse against employees, those employees will be removed from care of vulnerable adults immediately and ongoing pending the results of the investigation." o The Directors of Program Services, Director of Nursing, Program Supervisors, Program Staff, and Managers On Call have been trained on the revised procedure. Please see attached. • The "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" states: "**injury of unknown origin of a client, will be reported immediately** by the mandated reporter, by one of the following methods: 1) make an internal report by completing the First Report of Incident Form and communicating this to the designated nurse (primary contact person) and administrator immediately, and make an oral report immediately to the Minnesota Adult Abuse Reporting Center, or; 2) will make an external report orally or online directly to the Minnesota Adult Abuse Reporting Center (MAARC) immediately and to the Axis Administrator immediately." o The Directors of Program Services, Director of Nursing, Program Supervisors, Program Staff, and Managers On Call have been retrained on the procedure. Please see attached. (Continued on page 13 of 17)	
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 immediately report an allegation of abuse and injury of unknown origin to the designated State Agency (SA) for 2 of 3 clients (C1, C2) reviewed for client safety. Findings include: C1's profile, undated, indicated C1 diagnoses included mild intellectual disability, anxiety disorder, and borderline personality disorder.	W 153		

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W 153	Continued From page 12 C1's Coordinated Services and Support Plan (CSSP) dated 2/1/23, indicated C1 needed care as a vulnerable adult. C1 needed to reside in a safe and protected environment, with a 24-hour plan of care delineating the provision of ongoing, daily care, supervision, monitoring, assistance, guidance, direction, training and support, in the least restrictive, most normative setting possible. C2's profile, undated, indicated diagnoses included depression, mood disorder, moderate intellectual disabilities, obsessive-compulsive disorder, anxiety disorder. C2's Intensive Support Services Assessment (ISSA) dated 12/2/23, indicated C2 tolerates staff assistance and cooperates with transfers. C2 is ambulatory and able to use his walker. C2 does not always use his walker and has a history of falls. C2 has a leg length discrepancy which results in an unsteady gait. C2 was a fall risk as he moves around a lot and constantly goes to the bathroom, which puts him at an increase risk for falling. Sometimes C2 will either forget or choose not to use his walker. When C2 is not using his walker, he walks quickly in a rushed manner which results in unsteadiness. Facility incident report dated 11/9/23 at 5:00 p.m., indicated staff forgot C1 plans after work to attend a family event. C1 swore profanities and threw pictures frames around the house. C1 claimed staff hit them, there were no markings. On-call supervisor received a call from DSP-A and DSP-A was "screaming at C1 in the background in his attempts to de-escalate". Facility failed to report incident of alleged abuse to the state agency (SA) immediately. Report was filed with SA on 11/10/23 at 10:20 a.m.	W 153	Procedure for implementing the POC • The Chief Operations Officer has trained the Directors of Program Services and the Director of Nursing on the policy revisions to the "Vulnerable Adults Maltreatment Reporting and Internal Review Policy". o The Director of Program Services has trained the Program Supervisors, Program Staff, and Managers On Call on the revised policy. • The Chief Operations Officer has retrained the Directors of Program Services and the Director of Nursing on reporting immediately to the MAARC as outlined in the "Vulnerable Adults Maltreatment Reporting and Internal Review Policy". o The Director of Program Services has retrained the Program Supervisors, Program Staff, and Managers On Call on reporting immediately to the MAARC as outlined in the "Vulnerable Adults Maltreatment Reporting and Internal Review Policy". o Program staff who are on LOA will be trained on procedure upon their return. Monitoring the POC • Program Supervisors and Managers On Call will ensure the "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" is adhered to. • The Directors of Program Services Title of the person responsible for the POC • Chief Operations Officer • The Director of Programs Services upon knowledge of an allegation abuse will ensure the policy was followed as written. Date by which the plan will be completed. o 12/8/2023	

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W 153	Continued From page 13 Facility incident report dated 10/29/23 at 12:00 p.m., indicated C2 had an unexplained injury above right eye. The unexplained injury is a bruise that is purple in color and about 2 inches by 1 inch. There was no speculation or thoughts on what caused the injury. Axis will be completing an internal investigation. C2 has not been impacted by the unexplained injury. C2 is not experiencing any pain. When asked about the injury, C2 told reporter, "leave C2 alone, nothing happened". Facility failed to report incident of injury of unknown origin to the SA immediately. Report was filed with SA on 10/29/23 at 4:27 p.m. During phone call interview on 11/21/23 at 12:49 p.m., on-call supervisor (OCS) confirmed he met with C1 at the facility due to a "mental health crisis". OCS stated a call was received by DSP-A and "he was yelling at C1 over the phone" and there was no attempt to de-escalating the situation made by DSP-A. OCS arrived at the facility and met with C1 in her room and C1 requested to not have DSP-A work with her as she was scared. OCS stated DSP-A was not sent home and did work the rest of his shift which included 3 hours of working alone. OCS stated DSP-A did not work with C1 however was allowed to work at other facility locations with vulnerable adults. OCS confirmed a report to the SA was late, OCS stated "I thought it was 24 hours to report." During interview on 11/22/23 at 12:22 p.m., qualified intellectual disability professional (QIDP) stated report to SA was late due to being short staff on the day of discovering a bruise. QIDP stated if there is an injury a report would be made in 2 hours to the SA.	W 153		

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W 153	Continued From page 14 Facility policy titled "Vulnerable Adults Maltreatment Reporting and Internal Review Policy" dated 6/26/15 indicated All knowledge of suspected abuse, neglect or exploitation of an individual served by AXIS will be reported immediately (within 24 hours) by the mandated reporter. Upon receiving the initial report of the incident the primary contact Director of Program Services shall immediately initiate internal investigative procedures.	W 153	W 154 Plan for correcting the deficiency • Axis policy "Investigation Procedures for an Incident involving Abuse or Neglect" has been revised to include the following statements: o Upon the knowledge of an allegation of abuse or neglect the program supervisor/manager on call must **immediately:** -Ensure the safety of all clients and staff. -Remove the alleged perpetrator from contact with Vulnerable Adults and not allow the alleged perpetrator to have access to vulnerable individuals pending the results of the investigation. - Provide any evidence you have collected or have knowledge of to the investigator. o All known witnesses or any person who may have information related to the incident must be interviewed. o All investigation interviews and other evidence must be documented and included in the investigation summary. o The Directors of Program Services, Director of Nursing, Program Supervisors, and Managers will be trained on the revised procedure. Procedure for implementing the POC • The Director of Program Services has revised the "Investigation Procedures for an Incident involving Abuse or Neglect". • The Director of Program Services will train the Program Supervisors and Managers On Call on the revised procedure. Monitoring the POC • The Director of Program Services will ensure: o All allegations of abuse or neglect of a vulnerable adult are investigated thoroughly and in accordance with the procedure.	
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 (C1) reviewed for staff to client abuse. Findings include: C1's profile, undated, indicated C1 diagnoses included mild intellectual disability, anxiety disorder and borderline personality disorder. C1's Individual Abuse Prevention Plan (IAPP) dated 2/13/23, indicated C1 was susceptible to abuse by having inability to identify potentially dangerous situations, lack of community orientation skills, inappropriate interactions with others, inability to deal with verbally/physically aggressive persons, verbally abusive to others. C1 is supervised by staff, family members, or approved friends whenever out in the community, at work, or home. If staff observe a	W 154		

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W 154	Continued From page 15 potential/actual abusive situation, they will take steps to reduce harm to by using verbal redirection or seeking help from others. Staff will intervene if C1 appears uncomfortable with another person's interactions or if she appears to be in danger of exploitation or abuse. Facility incident report dated 11/9/23 at 5:00 p.m., indicated staff forgot C1 plans after work to attend a family event. C1 swore profanities and threw pictures frames around the house. C1 claimed staff hit them, there were no markings. On-call supervisor received a call from DSP-A and DSP-A was "screaming at C1 in the background in his attempts to de-escalate". During interview on 11/22/23 at 12:39 p.m., director of program services (DPS) confirmed she was the lead investigator for the 11/9/23 allegation of abuse. DPS indicated she completed the interview with DSP-A and DSP-B and concluded there was no harm physically or verbally to C1 but "missed following protocol and was not professional". DPS stated DSP-A was not suspended during the investigation, "we missed that". DPS confirmed watching the available camera footage was not part of the investigation and not all witnesses were interviewed. DPS also indicated the facility did not substantiate the incident as abuse.The plan of correction was to re-educate DSP-A and to give him a warning. However, nothing had been completed yet and DSP-A had already returned to work. DPS stated being aware of DSP-A recent employee write ups however was not aware of the most recent concern on 11/2/23. Facility policy titled "Vulnerable Adults Maltreatment Reporting and Internal Review	W 154	○ Any evidence and investigation interviews are thoroughly documented according to the procedure. Title of the person responsible for the POC • Director of Program Services Date by which the plan will be completed. ○ 12/22/2023	

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W 154	Continued From page 16 Policy" dated 6/26/15 indicated it is the policy of AXIS Alternatives to protect the adults served who are vulnerable to maltreatment and to require the reporting of suspected maltreatment of vulnerable adults. All individuals will be cared for with respect and will be protected from any abuse, neglect or exploitation. All knowledge of suspected abuse, neglect or exploitation of an individual served by AXIS will be reported immediately (within 24 hours) by the mandated reporter. Upon receiving the initial report of the incident the primary contact Director of Program Services shall immediately initiate internal investigative procedures. Investigating procedures shall include but not be limited to: physical examination, written report regarding injuries, interviews with the person reporting the incident and any witnesses to the incident, written reports by all persons involved, interview with the perpetrator of the allegation, records of any previous abuse and update and provide final reports to the Director of Program Services as soon as possible. Any time during the investigation, the alleged perpetrator may be dismissed from work pending further investigation. Upon completion of the internal investigation, a conclusion will be made and appropriate disciplinary actions may be imposed upon the employee.	W 154		

Vulnerable Adults Maltreatment Reporting and Internal Review Policy (includes definitions of abuse and neglect)
Reporting Suspected Maltreatment of a Vulnerable Adult - Reporting Plan, Internal Review, Procedures and
Definitions

Course 134
Record 2100

8/16/22

5/26/22

11/28/23

Axis needs to ensure that each new employee (i.e., mandated reporter), receives an orientation within 72 hours of first providing direct contact services to a vulnerable adult and annually thereafter.

The orientation and annual review shall inform the mandated reporters of:

- the reporting requirements and definitions

- the requirements of this section

- the license holder's program abuse prevention plan, and;

- and all internal policies and procedures related to the prevention and reporting of maltreatment of individuals receiving services.

Who Should Report

All Axis staff are mandated reporters and are required to report. Any family member or IDT member or other persons may voluntarily report abuse or neglect.

Reporting Procedures

Where To Report

All knowledge of and written information about alleged or suspected abuse, neglect, financial exploitation, injury of unknown origin of a client, or, physical aggression of one client to another client served by Axis, will be reported immediately by the mandated reporter, by one of the following methods:

1) make an internal report by completing the First Report of Incident Form and communicating this to the designated nurse (primary contact person) and administrator immediately, and make an oral report immediately to the Minnesota Adult Abuse Reporting Center, or;

2) will make an external report orally or online directly to the Minnesota Adult Abuse Reporting Center (MAARC) immediately and to the Axis Administrator immediately.

"Immediately" means there should be no delay between staff awareness of the allegation and reporting to the administrator unless the situation is unstable at the time the allegation comes to the attention of the staff. In this case, reporting should occur as soon as the safety of all clients is assured and all necessary emergency measures have been taken.

When the administrator is not on duty, the Director of Program Services will be acting in the administrator's absence.

Axis expects that such reporting is always made to the administrator unless the administrator is suspected to be involved in the mistreatment, neglect or injury) and that the administrator will ensure that the appropriate State officials are notified. In any instance where a staff member is concerned that the administrator may have been involved in an incident of mistreatment, neglect, abuse or injury, the staff member will make a report to the Director of Program Services.

The secondary contact person (Program Supervisor) shall be involved when there is reason to believe that the primary contact person (designated nurse) is involved in the alleged or suspected maltreatment.

If the primary contact person is involved in the alleged or suspected abuse, neglect, financial exploitation, injury of unknown origin of a client, or, physical aggression on one client to another client served by Axis:

1) the mandated reporter will make an internal report by completing the First Report of Incident and communicating this to the secondary contact person (Program Supervisor) and immediately to the Axis Administrator, and make an external oral report immediately to the Minnesota Adult Abuse Reporting Center (MAARC). Upon notification, the Axis Administrator will contact the Director of Program Services and they will jointly conduct the investigation.

2) the mandated reporter will make an external oral report directly to the Minnesota Adult Abuse Reporting Center (MAARC) 844-880-1574 immediately and Axis Administrator immediately.

The primary or secondary contact person, upon receipt of alleged or suspected abuse, neglect, financial exploitation, injury of unknown origin of a client, or, physical aggression of one client to another client served by Axis, will report to the administrator immediately and the Minnesota Adult Abuse Reporting Center (MAARC) immediately and other required contacts such as the legal guardian and county case manager. Reporters who make good faith reports are immune from retaliation. When an internal report is made in which maltreatment is alleged, the mandated reporter(s) shall be given a copy of the confidential "Notice of status of report of suspected maltreatment" or email equivalent within 2 working days of their report. The Notice shall include the statement that the reporter has the right to report the alleged maltreatment to an external agency and that Axis cannot retaliate against the reporter.

What To Report

Actual or suspected physical abuse, neglect or sexual abuse.

Any client allegation of suspected physical abuse, neglect or sexual abuse.

Any "injury of unknown origin of a client" which means:

a. the source of the injury was not witnessed by any person, and;

b. the source of the injury could not be explained by the client, and;

c. 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 observed at one particular point in time or the incidence of injuries over time.

d. Any medical emergency, unexpected serious illness, or significant unexpected changes in an illness or medical condition of a person that requires the program to call 911, physician, advanced registered nurse, or physician assistant treatment, or hospitalization. MN. Stat. 245.91 subd. 6 (2022).

Failure To Report

State law requires that all mandated reporters must report incidents of abuse, neglect & exploitation.

A mandated reporter who negligently or intentionally fails to report is liable for damages caused by the failure to report.

Retaliation Prohibited

Reporters who make good faith reports are immune from retaliation. When an internal report is made in which maltreatment is alleged, the mandated reporter(s) shall be given a copy of the confidential "Notice of status of report of suspected maltreatment" or email equivalent within 2 working days of their report. The Notice shall include the statement that the reporter has the right to report the alleged maltreatment to an external agency and that Axis cannot retaliate against the reporter.

Internal Investigation

Upon receiving the initial report of the incident, the primary or secondary contact person shall immediately contact the Axis Administrator. Upon notification, the Axis Administrator will contact the Director of Program Services and they will jointly conduct the investigation.
Investigating procedures shall include but not be limited to:

- physical examination by appropriate medical personnel if a physical injury or sexual assault is involved,

- including a written report of the nature and extent of the injuries;

- interviews with the person reporting the incident and any witnesses to the incident;

- a review of all relevant documentation, including progress notes, physician's orders, and plans of care.

- written reports by all persons involved including place, date and time of occurrence and the nature of the nature of the suspected abuse, neglect or exploitation;

- interview with the person reported as perpetrating the suspected abuse, neglect or exploitation including a written response to the allegation;

- records of any previous abuse, neglect or exploitation, and;

- periodic updates and a final report to the Director of Program Services as soon as possible.

Any time during the investigation for allegations of abuse against employees, those employees will be removed from care of vulnerable adults immediately and ongoing pending the results of the investigation.

Upon the completion of the initial investigation, the investigator shall immediately forward all the material and results of the investigation to the appropriate authority if they request it.

Original reports will be maintained in confidence at the facility or AXIS Corporate Office.

Reports to the outside authority by the primary contact person requires a response to the initial reporter, that the Minnesota Adult Abuse Reporting Center (MAARC) has been called. It is the agency's responsibility to assure that the report is made and must give written notice within two working days to the initial reporter whether the internal report was passed on to the Minnesota Adult Abuse Reporting Center (MAARC). The "Notice of Status of report of suspected maltreatment" form or an e-mail equivalent notice will be used.

Primary and Secondary Person or Position to Ensure Internal Reviews are Completed

Axis has two Directors of Program Services. The internal review will be completed by the Axis Directors of Program Services. If this individual is involved in the alleged or suspected maltreatment, the other Directors of Program Services will be responsible for completing the internal review.

Internal Review

The primary or secondary person (Program Supervisor or Manager on Call) will use the Incident Reporting Form to review internal and external reports for purposes of evaluation as to whether:

(a) related policies and procedures were followed;

(b) whether the policies and procedures were adequate;

(c) whether there is a need for additional staff training;

(d) whether the reported event is similar to past events with vulnerable adults or the services involved, and;

(e) whether there is a need for corrective action by Axis to protect the health and safety of vulnerable adults.

AXIS shall ensure that an internal review is completed and that corrective action is taken as necessary to protect the health and safety of vulnerable adults when the facility has reason to know that an internal or external report of alleged or suspected maltreatment has been made.

Internal reviews and final reports shall be documented and include original written material gathered in the investigation, names of persons involved, persons interviewed,

investigating authority notified, written summary of all findings by the person conducting the investigations, and all conclusions reached and actions taken and all information relative to previous abuse. All reports shall be dated and include the signature and title of the person writing the report. Internal review summaries are accessible to the commissioner upon the commissioner's request. The documentation provided to the commissioner by AXIS may consist of a completed checklist that verifies completion of each of the requirements of the review.

Results of all investigations must be reported to the administrator or designee within five (5) working days of the incident.

Corrective Action Plan

Based upon the results of this review, Axis will develop, document and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by individuals or Axis, within five (5) working days.

Upon the completion of the internal investigation, a conclusion will be made and appropriate disciplinary actions may be imposed upon the employee.

Documentation of the Internal Review

The Axis Director of Program Services shall document that the internal review has been completed and will provide this documentation to the appropriate authorities.

Reports should be made to the department in the county in which the maltreatment occurred. A follow-up report should be made to the person's host county, if it is different from the county in which the maltreatment occurred.

Upon request, outside reports will go to

Minnesota Adult Abuse Reporting Center (MAARC) 844-880-1574

The consumer's legal representative: (locate phone number in Contacts database)

The consumer's case manager: (locate phone number in Contacts database)

Final reports shall include original written material gathered in the investigation, names of persons involved, persons interviewed, investigating authority notified, written summary of all findings by the person conducting the investigations, and all conclusions reached and actions taken and all information relative to previous abuse. All reports shall be dated and include the signature and title of the person writing the report.

The conduct of the investigation and all records of the investigation shall be treated with utmost confidentiality.

Staff Training

Axis shall ensure that each new mandated reporter receives an orientation within 72 hours of first providing direct contact services to a vulnerable adult and semi-annually thereafter. The orientation and semi-annual review shall inform the mandated reporter of the reporting requirements and definitions under Minnesota Statutes, sections 626.557 and 626.5572, the requirements of Minnesota Statutes, section 245A.65, the license holder's program abuse prevention plan, and all internal policies and procedures related to the prevention and reporting of maltreatment of individuals receiving services.

AXIS Minnesota, Inc. will document the provision of this training, monitor implementation by staff, and ensure that the policy is readily accessible to staff, as specified under Minnesota Statutes, section 245A.04, subdivision 14.

245A.65 License holder requirements governing maltreatment of vulnerable adults.

Subd. 3. Orientation of mandated reporters. The license holder shall ensure that each new mandated reporter, as defined in section 626.5572, subdivision 16, who is under the control of the license holder, receives an orientation within 72 hours of first providing direct contact services as defined in section 245C.02, subdivision 11, to a vulnerable adult and annually thereafter.

The orientation and annual review shall inform the mandated reporters of:

- the reporting requirements and definitions in sections 626.557 and 626.5572;

- the requirements of this section;

- the license holder's program abuse prevention plan, and;

- and all internal policies and procedures related to the prevention and reporting of maltreatment of individuals receiving services.

Reporting of Serious injuries or deaths - ICF-IID Homes

Serious injuries or deaths of individuals who live in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Home such as Axis on Belmont, Axis on Glenhill, Axis on Eldridge, Axis on Seneca, Axis on St. Michael or Axis on White Bear Ave.), must be reported to two separate agencies.

1. Office of Ombudsman for Mental Health and Intellectual Disability by completing and faxing two forms to them:

- "Death or Serious Injury Report - Fax Transmission Cover Sheet" to (651) 431-7673. If it is an individual's death, fax the completed "Death Report" (Document Library) to (651) 296-1021. If this is to report serious injury, you should fax the "Serious Injury Report" to the Ombudsman office at (651) 296-1021, and then a call of the death or serious injury must be made to:

2. Minnesota Department of Health - Office of Health Facility Complaints (OHFC) by calling 651-201-4201.

Notification

The policy shall be made available to all individual's at her/his admission conference with review and documentation in their annual individual abuse prevention plan. If individuals are unable to comprehend this plan, their representative shall be given the opportunity to receive the orientation with documentation in the individual's abuse prevention plan.

Orientation to this policy must be given to all staff persons at the time of hire, and semi-annually thereafter. This policy will be posted in a prominent place (i.e., Easy AXIS) in each facility. Copies shall be made available upon request to individuals.

This policy will be posted in a prominent place in each facility. Copies shall be made available upon request to individuals.

626.5572 Definitions.

Scope. For the purpose of section 626.557, the following terms have the meanings given them, unless otherwise specified.

Abuse. "Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

Clarifying note: Physical aggression by one vulnerable adult to another needs to be communicated immediately to the Axis Administrator, nurse and immediately to the Minnesota Adult Abuse Reporting Center (MAARC)

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Clarifying note: Any allegation from a client that s/he has been verbally abused by a caregiver, needs to be communicated immediately to the Axis Administrator and orally to the Minnesota Adult Abuse Reporting Center (MAARC) immediately.

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

(e) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C or 252A, or

section 253B.03 or 525.539 to 525.6199, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult or, where permitted under law, to provide nutrition and hydration parenterally or through intubation. This paragraph does not enlarge or diminish rights otherwise held under law by:

(1) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(2) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct.

(f) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult.

(g) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(1) a person, including a facility staff person, when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(2) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship.

Accident. "Accident" means a sudden, unforeseen, and unexpected occurrence or event which:

(1) is not likely to occur and which could not have been prevented by exercise of due care; and

(2) if occurring while a vulnerable adult is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

Caregiver. "Caregiver" means an individual or facility who has responsibility for the care of a vulnerable adult as a result of a family relationship, or who has assumed responsibility for all or a portion of the care of a vulnerable adult voluntarily, by contract, or by agreement.

Common entry point. "Common entry point" means the entity designated by each county responsible for receiving reports under section 626.557. As of July 1, 2015 this has been changed to a statewide "Common Entry Point" called the Minnesota Adult Abuse Reporting Center (MAARC).

Facility. (a) "Facility" means a hospital or other entity required to be licensed under sections 144.50 to 144.58; a nursing home required to be licensed to serve adults under section 144A.02; a residential or nonresidential facility required to be licensed to serve adults under sections 245A.01 to 245A.16; a home care provider licensed or required to be licensed under section 144A.46; a hospice provider licensed under sections 144A.75 to 144A.755; or a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, and 256B.0627.

(b) For home care providers and personal care attendants, the term "facility" refers to the provider or person or organization that exclusively offers, provides, or arranges for personal care services, and does not refer to the client's home or other location at which services are rendered.

False. "False" means a preponderance of the evidence shows that an act that meets the definition of maltreatment did not occur.

Final disposition. "Final disposition" is the determination of an investigation by a lead agency that a report of maltreatment under Laws 1995, chapter 229, is substantiated, inconclusive, false, or that no determination will be made. When a lead agency determination has substantiated maltreatment, the final disposition also identifies, if known, which individual or individuals were responsible for the substantiated maltreatment, and whether a facility was responsible for the substantiated maltreatment.

Financial exploitation. "Financial exploitation" means:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

Immediately" means there should be no delay between staff awareness of the allegation and reporting to the administrator unless the situation is unstable at the time the allegation comes to the attention of the staff. In this case, reporting should occur as soon as the safety of all clients is assured and all necessary emergency measures have been taken.

Inconclusive. "Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Initial disposition. "Initial disposition" is the lead agency's determination of whether the report will be assigned for further investigation.

Lead investigative agency. "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home, whether a private home or a housing with services establishment registered under chapter 144D, including those that offer assisted living services under chapter 144G.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, family adult day services, mental health programs, mental health clinics, chemical dependency programs, the Minnesota sex offender program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services.

(c) The county social service agency or its designee is the lead investigative agency for all other reports, including, but not limited to, reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659.

Legal authority. "Legal authority" includes, but is not limited to: (1) a fiduciary obligation recognized elsewhere in law, including pertinent regulations; (2) a contractual obligation; or (3) documented consent by a competent person.

Maltreatment. "Maltreatment" means abuse as defined in subdivision 2, neglect as defined in subdivision 17, or financial exploitation as defined in subdivision 9.

Amendment: Serious maltreatment. (a) "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. (b) For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include:

(1) diagnostic testing, assessment, or observation.;

(2) the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or

(3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment.

(c) For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke

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(d) Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult. [Laws of Minnesota 2010, chapter 329, article 1, section 14].

Note: It Clarifies when neglect results in serious injury which "reasonably requires the care of a physician." This subdivision now specifically includes care by a physician assistant or nurse practitioner, but excludes an injury treated solely by applying or recommending a remedy that is available over the counter without a prescription. It also specifically excludes an injury treated with a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. If a victim of neglect has injuries falling into one of these exclusions, the subject will no longer be disqualified for serious maltreatment.

Mandated reporter. "Mandated reporter" means a professional or professional's delegate while engaged in: (1) social services; (2) law enforcement; (3) education; (4) the care of vulnerable adults; (5) any of the occupations referred to in section 214.01, subdivision 2; (6) an employee of a rehabilitation facility certified by the commissioner of jobs and training for vocational rehabilitation; (7) an employee or person providing services in a facility as defined in subdivision 6; or (8) a person that performs the duties of the medical examiner or coroner.

Neglect. "Neglect" means:

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

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

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

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or

section 253B.03, or 525.539 to 525.6199, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or

(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in sexual contact with:

(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

(iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

(d) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(e) If the findings of an investigation by a lead investigative agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (c), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. An individual will not be found to have neglected or maltreated the vulnerable adult based solely on the facility's not having taken the actions required under paragraph (c), clause (5), item (iv), (v), or (vi). This must not alter the lead investigative agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph (c).

Report. "Report" means a statement concerning all the circumstances surrounding the alleged or suspected maltreatment, as defined in this section, of a vulnerable adult which are known to the reporter at the time the statement is made.

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

Therapeutic conduct. "Therapeutic conduct" means the provision of program services, health care, or other personal care services done in good faith in the interests of the vulnerable adult by: (1) an individual, facility, or employee or person providing services in a facility under the rights, privileges and responsibilities conferred by state license, certification, or registration; or (2) a caregiver.

Vulnerable adult. "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services at or from a facility required to be licensed to serve adults under sections 245A.01 to 245A.15, except that a person receiving outpatient services for

treatment of chemical dependency or mental illness, or one who is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under section 144A.46; or from a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, and 256B.0627; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment. (b) For purposes of this subdivision, "care or services" means care for the health, safety, welfare, or maintenance of an individual.

(b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual.