

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email on April 6, 2021

Administrator People II 1380 West Minnehaha Parkway Minneapolis, MN 55419

RE: Event ID: T38Y11

Dear Administrator:

On March 17, 2021, 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 electonically 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:

Susie Haben, Unit Supervisor St. Cloud B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

Sincerely,

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

Kim Typon

Email: kim.tyson@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed on April 6, 2021

Administrator People II 1380 West Minnehaha Parkway Minneapolis, MN 55419

Re: Project Number Event ID: T38Y11

Dear Administrator:

The above facility survey was completed on March 17, 2021 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56.

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

Sincerely,

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

Kim Typon

Email: kim.tyson@state.mn.us

Minnesota Department of Health

MAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419  PREPRIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  PREPRIX TAG  SOUND Initial Comments  In accordance with Minnesota Statute, section 144.563, 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, faiture to comply with any of the items will be considered tack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.  You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance On March 16th and 17th, 2021, a complaint investigation was conducted. The following complaint(s) was found to be UNSUBSTANTIATED:  HG435019C (MN00070895) - no licensing orders were issued HG435020C (MN00059094) - no licensing orders		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1380 WEST MINNEHAHA PARKWAY  MINNEAPOLIS, MN 55413    (KA) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PREPRY						_	
PEOPLE II   SUMMARY STATEMENT OF DEFICIENCIES   CACH DEFICIENCY MINNEAPOLIS, MN 56419   PREPRIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREPRIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   CACH CACH CACH CACH CACH CACH CACH CA			01556	B. WING		03/1	7/2021
MINNEAPOLIS, MN 55419   MINNEAPOLIS, MN 5445   MINNEAPOLIS,	NAME OF	PROVIDER OR SUPPLIER					
Page	PEOPLE	II					
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Your facility is IN compliance with requirements of		In accordance with 144.56 and/or Minn 144.653, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Departments of the Minnesota Departments of the Minnesota Departments of the number and MN Ruindicated below. Wiseveral items, failur items will be consided Lack of compliance item of multi-part ruices assessment of a finition violated during the incorrected.  You may request a that may result from orders provided that the Department with notice of assessme On March 16th and investigation was concomplaint(s) was found under the department with notice of assessme On March 16th and investigation was complaint(s) was found under the department with notice of assessme On March 16th and investigation was complaint(s) was found under the department with notice of assessme On March 16th and investigation was complaint(s) was found under the department with notice of assessme On March 16th and investigation was complaint(s) was found under the department with notice of assessme On March 16th and investigation was complaint(s) was found under the department with notice of assessme On March 16th and investigation was complaint(s) was found the department with notice of assessme On March 16th and investigation was complaint(s) was found the department with notice of assessme On March 16th and investigation was complainted the department with notice of assessme On March 16th and investigation was completed the department with notice of assessme On March 16th and investigation was completed the department with notice of assessme On March 16th and investigation was completed the department with notice of assessme On March 16th and investigation was completed the department with notice of assessme On March 16th and investigation was completed the department with notice of assessme On March 16th and investigation was completed the department with notice of assessme On March 16th and investigation was completed the department with notice of assessme On March 16th	esota Statute, section otion order has been issued y. If, upon reinspection, it is iency or deficiencies cited octed, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.  The ther a violation has been compliance with all a rule provided at the tag alle number or MN Statute of the arule or statute contains the to comply with any of the ered lack of compliance. It is upon re-inspection with any alle will result in the even if the item that was initial inspection was  The aring on any assessments in non-compliance with these that a written request is made to be a written request is made to be and for non-compliance.  To the compliance of a complaint onducted. The following and to be according orders  10070895) - no licensing orders				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER.	A. BUILDING: _		COWIFE	IED
01556	B. WING		C 03/17/2021	
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5 000 Continued From page 1 Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).	5 000			

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Minnesota Department of Health STATE FORM

PRINTED: 04/01/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		24G435	B. WING _			/17/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PEOPLE	II			1380 WEST MINNEHAHA PARKWAY		
1 201 22				MINNEAPOLIS, MN 55419		
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E 000	Initial Comments		E 0	00		
W 000	was conducted Mar your facility by the M Health to determine Preparedness regu was in full complian INITIAL COMMENT	ΓS	W 0	00		
	survey was comple complaint investiga compliance with 42 requirements for Int Individuals with Inte	laints were found to be				
	cited	0070895) - no deficiencies 0059094) - no deficiencies				
W 455	Control survey was the Minnesota Depa compliance with §4 The facility was NO INFECTION CONT CFR(s): 483.470(I)(		W 4:	55		
	prevention, control, and communicable	and investigation of infection diseases.				
		s not met as evidenced by:		_		0.12) 2.17
LABORATOR'	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

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

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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NAME OF F	PROVIDER OR SUPPLIER			1380	EET ADDRESS, CITY, STATE, ZIP CODE  O WEST MINNEHAHA PARKWAY  INEAPOLIS, MN 55419	1 03/	17/2021
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W 455	Based on observator review the facility faconsistently screen COVID-19 upon enthe facility failed to protection to decreatransmission of CO potential to affect a facility, as well as sometimes.  Findings include:  Upon entry to the famental health specified the facility office to symptoms (S/S) of that MHS-A was we surgical mask with wearing prescription. At 9:25 a.m. the safe supervisor (PS) arridonning (wearing) a protection. After enand PS provided surported to the living room on the living next to it off because it was nasal dressing on a PS was not observed mask in common a alterative locations eye protection during the control of the co	cion, interview, and document ailed to ensure facility staff ed for signs and symptoms of try to the facility. Furthermore, ensure facility staff utilized eye ase the potential for VID-19. This practice had the II 6 clients residing in the taff and visitors.  Accility, on 3/16/21 at 9:10 a.m. is is is is in the screened for signs and COVID-19. It was observed earing a (medical grade) no eye protection (noted to be	W 4	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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W 455	arrived, noted to be no eye protection (or During observation MHS-A was meeting living room area. That a small round talk between them. C3, phone up and talking without a mask and up interview at 2:59 conference had entelephone conference. At 3:30 p.m. on 3/1 afternoon shift recent MHS-B was noted with no eye protect. On 03/17/2021 at 7 facility, surveyor was nurse (RN)-A who had morning to give a cobserved that RN-A but no eye protection was facility's COVID polfacility does have facility does have fa	e wearing a surgical mask with only prescription eyewear).  s on 3/16/21, at 2:21 p.m. g with C3 in the down stairs he MHS-A and C3 were sitting ple with 4 chairs, with no chairs who was holding the celling on speaker mode, was if MHS-A, was wearing a no eye protection. In a follow 0 p.m., after the telephone ded, MHS-A stated that the note began around 1:00 p.m.  6/21, MHS-B arrived for the eliving report from MHS-A. to be wearing a surgical mask ion.  7:55 a.m., after entering the as introduced to registered had come to the facility that lient a weekly injection. It was a was wearing a surgical mask on. In an interview with RN-A a.m., RN-A stated wearing not a requirement of the licy. MHS-A further stated the acce shields, however they it to wear them if a client is VID and awaiting tests results,	W 45	55			

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W 455	one staff person who off schedule for the In a review of the fa 3/16/21 and /17/21, surveyor were the chave been screene evidence of PS, PM screened this day.  A review of the facility, from February 2021) documented  > February 2021: b schedule, the February 2021) documented  > February 2021: b schedule, the February 2021: b schedule, the February 2021: b schedule from the facility. A twere unaccounted  > March 2021: base schedule from the COVID screening leentries (shifts/meet entry into the facility screenings were unaccounted to wear eyall staff were to self facility. PS was unabeen screening the this was being done sure who was to be this was being com	acility's COVID-19 staff log, for it was noted MHS-A and only persons documented to d that day. The log lacked 1 and MHS-B having been lity's staff COVID-19 screening 1, 2021 to present (March 17, the following:  ased on review of facility lary 2021 COVID screening ted 13 of 99 entries neduled which required entry otal of 86 staff screenings for.  ed on review of facility 1st-17th, the March 2021 og had a documented 9 of 66 ings scheduled which required y). A total of 54 staff faccounted for.  3/17/21, at 9:15 a.m. both PS by were unaware staff were en protection and verified that is screen upon entry to the laware that staff had not either mselves and/or documenting en Neither PS nor MHS-A were responsible for making sure	W 4	55			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED C		
		24G435	B. WING _		03	/17/2021	
PEOPLE	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	ODE	-	
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W 455	noted on Page 2, s face coverings can mask, a cloth mask bandanna, or a religobservations over to no staff using any odisposable surgical 3/17/21 at 9:15 a.m. they had obtained to have only been were PS stated she would needed update.  The facility policy, e Manual (updated 12 the following:  > Page 7 in the sect Control: Potential S "Employees must of the reporting to work self-assessment for the policy and manual employing uidelines as outling Control Framework. In regards goggles ONLY addressed updates.  > On page 14-15, updated 12 the following tasks:  > On page 14-15, updated 13 the following tasks:  > On page 14-15, updated 15 that the following aerosol general control general page 14-15. The face of the following tasks:  > On page 14-15, updated 15 that the following aerosol general control general page 14-15.	ection 2, subpart a.: "Types of include a paper or disposable a, a neck gaiter, a scarf, a gious face covering." During he two days of survey noted other face mask other than masks. During interview on a, PS and MHS-A stated once he required supplies, staff aring the appropriate masks. Id inform corporate of this entitled: COVID-19 Protocols 2/18/20 version 8) indicated estion entitled COVID - Infection and to complete a r symptom."  Inder the title of: All program anagers, the policy indicated ees are following the ed in the COVID - Infection ."  or face shields, the policy se of these items be worn in	W 45	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419		1172021
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W 455	> On page 24, unde Transportation Prod		W 4	55		

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NAME OF F	PROVIDER OR SUPPLIER	240433	D. WING		REET ADDRESS, CITY, STATE, ZIP CODE	03/	17/2021
PEOPLE	II				80 WEST MINNEHAHA PARKWAY NNEAPOLIS, MN 55419		
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E 000	Initial Comments		ΕO	000			4/30/21
W 000	was conducted Ma your facility by the I Health to determine Preparedness regu was in full compliar INITIAL COMMENT On March 16th and survey was comple complaint investigat compliance with 42 requirements for Interviously	d 17th, 2021, an abbreviated ated at your facility to conduct a ation. Your facility was IN CFR Part 483, subpart I, termediate Care Facilities for ellectual Disabilities.	W 0	000	Received 4/12/21 Approved 4/12/21 POC date 4/30/21		
W 455	cited HG435020C (MN0) cited  In addition, a COVI Control survey was the Minnesota Dep compliance with §4 The facility was NC INFECTION CONT CFR(s): 483.470(I).  There must be an a prevention, control, and communicable	(1) active program for the and investigation of infection	W 4	-55			
LABORATOR	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

see signature on last page

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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				MINNEAPOLIS, MN 55419			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 455	Based on observator review the facility faconsistently screen COVID-19 upon enthe facility failed to protection to decreatransmission of CO potential to affect a facility, as well as sometimes.  Findings include:  Upon entry to the famental health specithe facility office to symptoms (S/S) of that MHS-A was we surgical mask with wearing prescription. At 9:25 a.m. the sat supervisor (PS) arridonning (wearing) a protection. After enand PS provided suburing the tour at 9 surveyor visited with on the living room on asal surgery (note nose), had a surgictable sitting next to it off because it was nasal dressing on a PS was not observe mask in common a alterative locations eye protection during the tour in the living room of the li	tion, interview, and document ailed to ensure facility staff ed for signs and symptoms of try to the facility. Furthermore, ensure facility staff utilized eye ase the potential for IVID-19. This practice had the II 6 clients residing in the taff and visitors.  Acility, on 3/16/21 at 9:10 a.m. ialist (MHS)-A lead survey to be screened for signs and COVID-19. It was observed earing a (medical grade) no eye protection (noted to be	W 4	People Incorporated was not the eye protection requireme to this survey. Plan outlined to update policies and proced.  1. Staff will wear eye protection People II 2. Update COVID policy to acface shields 3. Monitoring Plan: Program Supervisor & Manager will specheck weekly  Person responsible: Director of Operations Dates: Staff wearing eye protection Policy updates 4/30/2021 Monitoring through 7/31/2021	nt prior pelow is dures.  on at ecount for  oot  immediate	4/30/21	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COM	E SURVEY PLETED
		24G435	B. WING _				C 1 <b>7/2021</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1380 WEST MINNEHAHA PARKWA MINNEAPOLIS, MN 55419		<u> </u>	1772021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPR	BE	(X5) COMPLETION DATE
W 455	arrived, noted to be no eye protection (or During observations MHS-A was meetin living room area. That a small round tab between them. C3, phone up and talkin without a mask and up interview at 2:59 conference had end telephone conference. At 3:30 p.m. on 3/1 afternoon shift rece MHS-B was noted to with no eye protection. On 03/17/2021 at 7 facility, surveyor was nurse (RN)-A who have morning to give a cobserved that RN-A but no eye protection was facility's COVID pol facility does have facility have only been told showing S/S of CO or providing close puring interview on (donning a surgical and MHS (donning there have been not	wearing a surgical mask with only prescription eyewear).  s on 3/16/21, at 2:21 p.m. g with C3 in the down stairs he MHS-A and C3 were sitting ble with 4 chairs, with no chairs who was holding the celling on speaker mode, was MHS-A, was wearing a no eye protection. In a follow p.m., after the telephone ded, MHS-A stated that the ce began around 1:00 p.m.  6/21, MHS-B arrived for the iving report from MHS-A. To be wearing a surgical mask on.  55 a.m., after entering the sintroduced to registered had come to the facility that lient a weekly injection. It was a was wearing a surgical mask on. In an interview with RN-A a.m., RN-A stated wearing not a requirement of the ficy. MHS-A further stated the face shields, however they to wear them if a client is VID and awaiting tests results,	W 4:	Policies were previously i enforcement was inadequed plan outlined below reinforpolicies.  1. Staff will re-direct clients masks in common areas and document any refusal. 2. Staff will be reminded of policy in a staff meeting 3. Monitoring Plan: Program & Manager will spot check  Person responsible: Director of Operations Dates: Staff will conduct reminders starting immediately Staff Meeting to remind of Monitoring through 7/31/20	uate. The proce curre to to wear and will the m Superv weekly s policy 4/8	e ent risor	4/30/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	I \ /	E SURVEY IPLETED
		24G435	B. WING		l	C <b>17/2021</b>
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		1772021
PEOPLE	II			1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 455	one staff person whoff schedule for the In a review of the fa 3/16/21 and /17/21, surveyor were the chave been screene evidence of PS, PM screened this day.  A review of the facil log, from February 2021) documented  > February 2021: bischedule, the February 2021) documented  > February 2021: bischedule, the February 2021: bischedule, the February 2021: bischedule, the February 2021: bischedule from the facility. A towere unaccounted in the facility of the facility screenings were unaccounted in the facility screening in the facility screening were unaccounted in the facility screenings were unaccounted in the facility screenings were unaccounted in the facility screenings were unaccounted in the facility screening in the facility scree	nom tested positive and was 10 days.  Icility's COVID-19 staff log, for it was noted MHS-A and only persons documented to d that day. The log lacked I and MHS-B having been  ity's staff COVID-19 screening 1, 2021 to present (March 17, the following:  ased on review of facility lary 2021 COVID screening ted 13 of 99 entries neduled which required entry otal of 86 staff screenings for.  ed on review of facility list-17th, the March 2021 og had a documented 9 of 66 ings scheduled which required v). A total of 54 staff faccounted for.  3/17/21, at 9:15 a.m. both PS by were unaware staff were en protection and verified that a screen upon entry to the ware that staff had not either mselves and/or documenting en Neither PS nor MHS-A were responsible for making sure	W 4	Policies were previously in enforcement was inadequated plan outlined below reinforce policies.  1. Staff will self-screen and on log every time they enter 2. Review and update COV improve compliance. 3. Program Supervisor & Previous Manager will create log notice sign-ins. Staff repeatedly mixing face disciplinary actions 4. Monitoring Plan: Program & Manager will review logs for the program of the program	document reflected the facility and facility and facility and facility are facility and facility and facility are facility and facility and facility and facility are facility and facility	4/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		24G435	B. WING				C / <b>17/2021</b>	
NAME OF PROVIDER OR SUPPLIER  PEOPLE II				1380	EET ADDRESS, CITY, STATE, ZIP CODE  D WEST MINNEHAHA PARKWAY  INEAPOLIS, MN 55419			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
W 455	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		W 4	V th T n re	When the policy was originally writthere were PPE supplies shortages The policy was not updated once nedical-grade face masks were more adily available.  . Update COVID policy to state face overings for staff must be medical-grace masks.  . Monitoring Plan: Compliance Special verify policy updates are ompleted after 4/30/2021.  Person responsible: Vice President of Operations Date: by 4/30/2021	ore e grade	4/30/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		24G435	B. WING		03/	17/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PEOPLE	п		1380 WEST MINNEHAHA PARKWAY			
PEOPLE	II .			MINNEAPOLIS, MN 55419		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION SHOULD FREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)		BE	(X5) COMPLETION DATE
W 455	Continued From pa > On page 24, under	ge 5	W 4	DEFICIENCY)		4/30/21
				Jill Wiedemann-West, CEO Signed 4/8/2021		