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

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

DEPARTMENT OF HEALTH

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01556	A. BUILDING: _____ B. WING _____	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEOPLE II	**1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419**

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On March 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 were issued Your facility is IN compliance with requirements of	5 000		

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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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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted March 16th and 17th, 2021 at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.475. The facility was in full compliance.	E 000		
W 000	INITIAL COMMENTS On March 16th and 17th, 2021, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following complaints were found to be UNSUBSTANTIATED: HG435019C (MN00070895) - no deficiencies cited HG435020C (MN00059094) - no deficiencies cited In addition, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.470 (I) Infection Control. The facility was NOT in full compliance.	W 000		
W 455	INFECTION CONTROL CFR(s): 483.470(I)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by:	W 455		

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

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

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W 455	Continued From page 1 Based on observation, interview, and document review the facility failed to ensure facility staff consistently screened for signs and symptoms of COVID-19 upon entry to the facility. Furthermore, the facility failed to ensure facility staff utilized eye protection to decrease the potential for transmission of COVID-19. This practice had the potential to affect all 6 clients residing in the facility, as well as staff and visitors. Findings include: Upon entry to the facility, on 3/16/21 at 9:10 a.m. mental health specialist (MHS)-A lead survey to the facility office to be screened for signs and symptoms (S/S) of COVID-19. It was observed that MHS-A was wearing a (medical grade) surgical mask with no eye protection (noted to be wearing prescription eyewear). At 9:25 a.m. the same day, the program supervisor (PS) arrived at the facility, only donning (wearing) a surgical mask, with no eye protection. After entrance conference, MHS-A and PS provided survey a tour of the facility. During the tour at 9:30 a.m., MHS-A, PS and surveyor visited with a client (C4) who was resting on the living room couch. C4, who recently had nasal surgery (noted a dressing taped under C4's nose), had a surgical mask next on the coffee table sitting next to her. C4 stated she had to take it off because it was difficult to breathe with the nasal dressing on and having to "mouth breath". PS was not observed re-directing C4 to wear her mask in common area, of the home, suggestion alterative locations to safely relax in, or donning eye protection during or after this interaction. On 3/16/21 at 11:00 a.m., the program director	W 455		

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W 455	Continued From page 2	W 455		

arrived, noted to be wearing a surgical mask with no eye protection (only prescription eyewear).

During observations on 3/16/21, at 2:21 p.m. MHS-A was meeting with C3 in the down stairs living room area. The MHS-A and C3 were sitting at a small round table with 4 chairs, with no chairs between them. C3, who was holding the cell phone up and talking on speaker mode, was without a mask and MHS-A, was wearing a surgical mask and no eye protection. In a follow up interview at 2:59 p.m., after the telephone conference had ended, MHS-A stated that the telephone conference began around 1:00 p.m.

At 3:30 p.m. on 3/16/21, MHS-B arrived for the afternoon shift receiving report from MHS-A. MHS-B was noted to be wearing a surgical mask with no eye protection.

On 03/17/2021 at 7:55 a.m., after entering the facility, surveyor was introduced to registered nurse (RN)-A who had come to the facility that morning to give a client a weekly injection. It was observed that RN-A was wearing a surgical mask but no eye protection. In an interview with RN-A and MHS-A at 8:14 a.m., RN-A stated wearing eye protection was not a requirement of the facility's COVID policy. MHS-A further stated the facility does have face shields, however they have only been told to wear them if a client is showing S/S of COVID and awaiting tests results, or providing close personal cares.

During interview on 3/17/21, at 8:53 a.m. PS (donning a surgical mask, with no eye protection) and MHS (donning only a surgical mask) stated there have been no client COVID cases in the house. Both staff members indicated to have had

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W 455	Continued From page 3	W 455		

one staff person whom tested positive and was off schedule for the 10 days.

In a review of the facility's COVID-19 staff log, for 3/16/21 and /17/21, it was noted MHS-A and surveyor were the only persons documented to have been screened that day. The log lacked evidence of PS, PM and MHS-B having been screened this day.

A review of the facility's staff COVID-19 screening log, from February 1, 2021 to present (March 17, 2021) documented the following:

> February 2021: based on review of facility schedule, the February 2021 COVID screening log had a documented 13 of 99 entries (shifts/meetings scheduled which required entry into the facility). A total of 86 staff screenings were unaccounted for.

> March 2021: based on review of facility schedule from the 1st-17th, the March 2021 COVID screening log had a documented 9 of 66 entries (shifts/meetings scheduled which required entry into the facility). A total of 54 staff screenings were unaccounted for.

During interview on 3/17/21, at 9:15 a.m. both PS and MHS stated they were unaware staff were required to wear eye protection and verified that all staff were to self screen upon entry to the facility. PS was unaware that staff had not either been screening themselves and/or documenting this was being done. Neither PS nor MHS-A were sure who was to be responsible for making sure this was being completed by all staff.

In review of the facility policy, the following was

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W 455	Continued From page 4	W 455		

noted on Page 2, section 2, subpart a.: "Types of face coverings can include a paper or disposable mask, a cloth mask, a neck gaiter, a scarf, a bandanna, or a religious face covering." During observations over the two days of survey noted no staff using any other face mask other than disposable surgical masks. During interview on 3/17/21 at 9:15 a.m., PS and MHS-A stated once they had obtained the required supplies, staff have only been wearing the appropriate masks. PS stated she would inform corporate of this needed update.

The facility policy, entitled: COVID-19 Protocols Manual (updated 12/18/20 version 8) indicated the following:

> Page 7 in the section entitled COVID - Infection Control: Potential Staff Illness documented "Employees must check their temperatures prior to reporting to work and to complete a self-assessment for symptom."

> Also on page 7, under the title of: All program Supervisors and Managers, the policy indicated "Ensure all employees are following the guidelines as outlined in the COVID - Infection Control Framework."

In regards goggles or face shields, the policy ONLY addressed use of these items be worn in the following tasks:

> On page 14-15, under the section titled: Direct Care for Clients with suspected COVID-19: Residential - that the facility recommended that during aerosol generating treatments (nebulizer, C-PAP, etc....) that eye protection should be worn.

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W 455	Continued From page 5 > On page 24, under the section titled: Transportation Procedure - "Surgical masks and goggles must be used by everyone in the vehicle..."	W 455		

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W 000	INITIAL COMMENTS On March 16th and 17th, 2021, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following complaints were found to be UNSUBSTANTIATED: HG435019C (MN00070895) - no deficiencies cited HG435020C (MN00059094) - no deficiencies cited In addition, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.470 (I) Infection Control. The facility was NOT in full compliance.	W 000	Received 4/12/21 Approved 4/12/21 POC date 4/30/21	
W 455	INFECTION CONTROL CFR(s): 483.470(I)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by:	W 455		

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

see signature on last page

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PEOPLE II	**1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419**

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W 455	Continued From page 3 one staff person whom tested positive and was off schedule for the 10 days. In a review of the facility's COVID-19 staff log, for 3/16/21 and /17/21, it was noted MHS-A and surveyor were the only persons documented to have been screened that day. The log lacked evidence of PS, PM and MHS-B having been screened this day. A review of the facility's staff COVID-19 screening log, from February 1, 2021 to present (March 17, 2021) documented the following: > February 2021: based on review of facility schedule, the February 2021 COVID screening log had a documented 13 of 99 entries (shifts/meetings scheduled which required entry into the facility). A total of 86 staff screenings were unaccounted for. > March 2021: based on review of facility schedule from the 1st-17th, the March 2021 COVID screening log had a documented 9 of 66 entries (shifts/meetings scheduled which required entry into the facility). A total of 54 staff screenings were unaccounted for. During interview on 3/17/21, at 9:15 a.m. both PS and MHS stated they were unaware staff were required to wear eye protection and verified that all staff were to self screen upon entry to the facility. PS was unaware that staff had not either been screening themselves and/or documenting this was being done. Neither PS nor MHS-A were sure who was to be responsible for making sure this was being completed by all staff. In review of the facility policy, the following was	W 455	Policies were previously in place, but enforcement was inadequate. The plan outlined below reinforce current policies. 1. Staff will self-screen and document on log every time they enter the facility 2. Review and update COVID policy to improve compliance. 3. Program Supervisor & Program Manager will create log noting missed sign-ins. Staff repeatedly missing sign-ins will face disciplinary actions. 4. Monitoring Plan: Program Supervisor & Manager will review logs weekly. Person responsible: Director of Operations Dates: Staff were reminded by email 3/17/2021 Staff reminder at meeting 4/8/2021 Policy updates 4/30/2021 Monitoring through 7/31/2021	4/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G435	A. BUILDING _____ B. WING _____	C 03/17/2021

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W 455	Continued From page 4 noted on Page 2, section 2, subpart a.: "Types of face coverings can include a paper or disposable mask, a cloth mask, a neck gaiter, a scarf, a bandanna, or a religious face covering." During observations over the two days of survey noted no staff using any other face mask other than disposable surgical masks. During interview on 3/17/21 at 9:15 a.m., PS and MHS-A stated once they had obtained the required supplies, staff have only been wearing the appropriate masks. PS stated she would inform corporate of this needed update. The facility policy, entitled: COVID-19 Protocols Manual (updated 12/18/20 version 8) indicated the following: > Page 7 in the section entitled COVID - Infection Control: Potential Staff Illness documented "Employees must check their temperatures prior to reporting to work and to complete a self-assessment for symptom." > Also on page 7, under the title of: All program Supervisors and Managers, the policy indicated "Ensure all employees are following the guidelines as outlined in the COVID - Infection Control Framework." In regards goggles or face shields, the policy ONLY addressed use of these items be worn in the following tasks: > On page 14-15, under the section titled: Direct Care for Clients with suspected COVID-19: Residential - that the facility recommended that during aerosol generating treatments (nebulizer, C-PAP, etc....) that eye protection should be worn.	W 455	When the policy was originally written, there were PPE supplies shortages. The policy was not updated once medical-grade face masks were more readily available. 1. Update COVID policy to state face coverings for staff must be medical-grade face masks. 2. Monitoring Plan: Compliance Specialist will verify policy updates are completed after 4/30/2021. Person responsible: Vice President of Operations Date: by 4/30/2021	4/30/21

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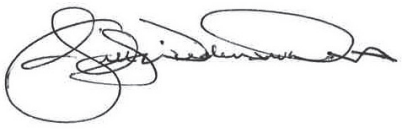
W 455	Continued From page 5 > On page 24, under the section titled: Transportation Procedure - "Surgical masks and goggles must be used by everyone in the vehicle..."	W 455	 **Jill Wiedemann-West, CEO** **Signed 4/8/2021**	4/30/21