

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

Administrator MTAI Bloomington 10633 Kell Ave So Bloomington, MN 55437

RE: Event ID: 9CB511

Dear Administrator:

On December 20, 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.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

Electonically enclosed is your copy of the Federal Forms CMS-2567.

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

Kim Tyson

Saint Paul, Minnesota 55164-0970

Phone: 651-201-3831

Email: kim.tyson@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 12/22/2021 FORM APPROVED OMB NO. 0938-0391

Name of provider or supplier   Street address, city, state, zip code   1683 KELL AVE SO   1683 KELL AVE SO		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING			SURVEY PLETED
MTAI BLOOMINGTON  (X4) ID PREFIX TAGE PROVIDER'S PLAN OF CORRECTION (PREFIX TAGE)  (X5) ID PREFIX TAGE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (X6) INITIAL COMMENTS  (D PREFIX TAGE)  (D PREFIX TAGE)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (D 12/20/21, an abbreviated survey was completed at your facility was in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.  The following complaint was found to be SUBSTANTIATED with no deficiencies cited: HG151006C (MN47459).  The following complaint was found to be UNSUBSTANTIATED with no deficiencies cited:	24G151		B. WING					
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 000  INITIAL COMMENTS  On 12/20/21, an abbreviated survey was completed at your facility was in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.  The following complaint was found to be SUBSTANTIATED with no deficiencies cited: HG151006C (MN47459).  The following complaint was found to be UNSUBSTANTIATED with no deficiencies cited:	NAME OF PROVIDER OR SUPPLIER			•	10633 KELL AVE SO			
On 12/20/21, 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 complaint was found to be SUBSTANTIATED with no deficiencies cited: HG151006C (MN47459).  The following complaint was found to be UNSUBSTANTIATED with no deficiencies cited:	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	X (EACH CORRE CROSS-REFERE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE		On 12/20/21, an a completed at your investigation. Your 42 CFR Part 483, s Intermediate Care Intellectual Disability. The following compsuBSTANTIATED HG151006C (MN4). The following compuNSUBSTANTIATED HG151005C (MN6).	bbreviated survey was facility to conduct a complaint facility was in compliance with subpart I, requirements for Facilities for Individuals with ties.  claint was found to be with no deficiencies cited: 7459).  claint was found to be ED with no deficiencies cited: 0103).					(Ve) 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.



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed on December 22, 2021

Administrator MTAI Bloomington 10633 Kell Ave So Bloomington, MN 55437

Re: Event ID: 9CB511

Dear Administrator:

The above facility survey was completed on December 20, 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

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Minnesota Department of Health

AND DIAN OF CORRECTION INDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
01098			B. WING		C <b>12/20/2021</b>	
NAME OF	PROVIDER OR SUPPLIER		I.	STATE, ZIP CODE	12/2	0/2021
MTAI BL	OOMINGTON		LL AVE SO			
	T		GTON, MN			(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
5 000	Initial Comments		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 12/20/21, a complaint investigation was conducted. Your facility was found to be in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).  The following complaint was found to be SUBSTANTIATED with no licensing orders issued: HG151006C (MN47459).					

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		01098	B. WING			C <b>12/20/2021</b>	
NAME OF PROVIDER O	R SUPPLIER		1	STATE, ZIP CODE	12/2	.0/2021	
MTAI BLOOMINGT	MTAI BLOOMINGTON  10633 KELL AVE SO BLOOMINGTON, MN 55437						
PREFIX (EACH	H DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
The follo UNSUBS issued:	ed From pa wing comp STANTIATE 05C (MN60	plaint was found to be ED with no licensing orders	5 000				

Minnesota Department of Health

STATE FORM 9CB511 If continuation sheet 2 of 2