

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

November 17, 2021

Administrator REM Hennepin Inc William 5100 William Ave Edina, MN 55436

RE: Event ID: XR3C11

Dear Administrator:

On November 4, 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:

Rem Hennepin Inc William

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

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 Typon

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

PRINTED: 11/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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W 000	INITIAL COMMEN	ΤS	wo	000				
W 153	completed at your finvestigation. Your with 42 CFR Part 4 Intermediate Care Intellectual Disability The following compsubstantial The following compsubstant	plaints were found to be 20078040), with no deficiency alt of the investigation, a d at W153. acceptable electronic POC, an ar facility may be conducted to antial compliance with the en attained. NT OF CLIENTS 20(2) Insure that all allegations of ect or abuse, as well as a source, are reported administrator or to other ance with State law through	W 1	153				
LABORATOR\	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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W 153	C1's Identification Sclient diagnoses of (MR) and Down's s records, Individual A (IAPP) dated 12/14 able to distinguish a himself against all pincrease to his vuln C2's Identification Sclient diagnoses of autism and attentio (ADHS). In a review 4/21/21, indicated C aggressive towards attempting to comm C2 is told to not do physically aggressive around him. Other aggression when Che may grab staff's arm. C2 did have a Incident report date receiving a report of it was discovered reprevious report that aggressed towards 9/3/21, 9/4/21, 9/30 10/11/21. An interm When interviewed of the state agency knowing. AD state management of abmake a report to the make a report to the state agency to the state agency to the state agency knowing. AD state management of abmake a report to the state agency to the s	Sheet (undated) indicated severe mental retardation yndrome. In a review of C1's Abuse Prevention Assessment /20, indicated C1 would not be all physical abuse or defend ohysical abuse causing an erability in this area. Sheet (undated) indicated severe to moderate MR, in deficit hyperactivity disorder of C2's records, IAPP dated C2 may become physically so thers when he would be nunicate his wants or needs. If something he would become we towards staff or others times he may display physical 2 wants to communicate and hand and drag them by the history of pinching as well. In 10/26/21 in regards to [C2], eviewing shift notes for the C2 held or physically [C1] on the following dates: //21, 10/2/21, 10/3/21, and all review had been initiated." In 11/4/21, at 10:02 a.m. area if these incidents were reported late due to management not distaff were to inform use, then management would e state. AD stated staff had when to report abuse.	W 15	53			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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W 153	When interviewed of quality improvement events were discovistated any abuse in the state agency righteen educated on these incidents were linear events were linear events. In a review of the factorial forms of abuse were reviewed in the state of the factorial forms of abuse were reviewed to the factorial factorial forms of abuse were reviewed to the factorial factor	on 11/4/21, at 10:20 a.m. at specialist (QIS) stated these ered upon record review. QIS acidents would be reported to ght away. QIS stated staff had reporting requirements after	W 1	53		

PRINTED: 11/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING				X3) DATE SURVEY COMPLETED	
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		24G200	B. WING			11/04/2021	
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PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		DATE
!		received 11/24/21	ļ		DEFICIENCY)		
		approved 12/1/21			W153		4
W 000	INITIAL COMMEN	TS Surie Haven	W		The facility must ensure that all alleg		12/3/21
		AMORAL 10000	L		of mistreatment, neglect or abuse, a		12/3/21
	On 11/3/21 - 11/4/2	21, an abbreviated survey was			as injuries of unknown source, are n		
		acility to conduct a complaint			immediately to the administrator or t		
	investigation. Your	facility was not in compliance			other officials in accordance with Stathrough established procedures.	ate law	
		83, subpart I, requirements for			illiough established procedures.	,	
	''	acilities for Individuals with			Any staff deficient in training will be	trained	
,	Intellectual Disabili	ties.			on Policy 5.1		
	The fellowing com	alainta arrana Carra d'Arriba			(Vulnerable Adult Reporting), as we	ll as	
	SUBSTANTIATED	olaints were found to be			Policy 12.1 (Administrative Review of		
		0078040), with no deficiency			Incidents) in regards to immediate re		
	cited.	00/8040), with no deficiency			for incidents including peer to peer p		-
	onea.				aggression or any other actions that		
	However, as a resu	Ilt of the investigation, a			be perceived as maltreatment/negle		
	deficiency was cite				addition, all staff will be trained usin		
					document outlining examples and s situations which staff would need to		i
		acceptable electronic POC, an			based on the previously completed		,
		ur facility may be conducted to			of shift note documentation and inci		
		antial compliance with the			reports.		
W 153	regulations has bee		337	153	•		1
W 133	CFR(s): 483.420(d)		***	133	A review of shift notes and incident		
	CFK(S). 463.420(d)	((2)			by the QIDP/Quality Improvement v	vill occur	
	The facility must en	nsure that all allegations of			on a weekly basis for a period of		
		ect or abuse, as well as			1 month, and if no issues, a review		
	, ,	n source, are reported			notes and incident reports will occur		
l	immediately to the	administrator or to other			regular basis to ensure that all releven reports are made in a timely manner		
l	1	nce with State law through			according to policy.	•	
ļ	established proceed		1		boots and to policy.		
		is not met as evidenced by:			Ongoing, all incidents of potential		
		and document review, the			allegations of abuse/neglect will be		
		oort allegations of client to client to the state agency (SA) for 1			reported immediately to the designation	ated	
		ho was being physically abused			state.		
	by another client.	no nas come physically abused					
	-, -, -, -, -, -, -, -, -, -, -, -, -, -				The corrections are implemented b		
	Findings include:				QIDP and will be monitored by the	Area	
					Director. Completion Date: 12/3/21		
LADORATO	N DIDECTOR'S OR PROVI	IDED/CLIDDI IED DEDDECENTATIVES OF	MATERIA	-	· ·		(VA) DATE
LABORATO	, —	DER/SUPPLIER REPRESENTATIVE'S SIG	^		TITLE	- 01	(X6) DATE
,	Just Kod	well_	لاو	جر	ional Director		<u>-714</u>

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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		24G200	B. WING			C 11/04/2021	
NAME OF PROVIDER OR SUPPLIER REM HENNEPIN INC WILLIAM				STREET ADDRESS, CITY, STATE, 2 5100 WILLIAM AVE EDINA, MN 55436			
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W 153	C1's Identification client diagnoses of (MR) and Down's records, Individual (IAPP) dated 12/14 able to distinguish himself against all increase to his vuln C2's Identification client diagnoses of autism and attentic (ADHS). In a reviet 4/21/21, indicated aggressive towards attempting to come C2 is told to not do physically aggress around him. Other aggression when Che may grab staff's arm. C2 did have a Incident report dat receiving a report it was discovered aprevious report the aggressed towards 9/3/21, 9/4/21, 9/3 10/11/21. An inter When interviewed director (AD) state to the state agency knowing. AD state management of ab make a report to the	Sheet (undated) indicated severe mental retardation syndrome. In a review of C1's Abuse Prevention Assessment 1/20, indicated C1 would not be all physical abuse or defend physical abuse causing an iterability in this area. Sheet (undated) indicated severe to moderate MR, on deficit hyperactivity disorder two of C2's records, IAPP dated C2 may become physically sothers when he would be municate his wants or needs. If the something he would become into towards staff or others times he may display physical C2 wants to communicate and and drag them by the a history of pinching as well. ded 10/27/21, indicated, "After on 10/26/21 in regards to [C2], reviewing shift notes for the at C2 held or physically [C1] on the following dates: 0/21, 10/2/21, 10/3/21, and mal review had been initiated." I on 11/4/21, at 10:02 a.m. area and these incidents were reported that due to management not end staff were to inform onse, then management would the staff were to inform onse, then management would the staff were to report abuse.		153			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 17, 2021

Administrator REM Hennepin Inc William 5100 William Ave Edina, MN 55436

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: XR3C11

Dear Administrator:

The above facility was surveyed on November 3, 2021 through November 4, 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 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.

When all orders are corrected, the first page of the order form should be signed and returned to:

Rem Hennepin Inc William

Page 2

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,

Kim Tyson

Kim Tyson, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health

Minnesota Department of Healt P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-3831

Email: kim.tyson@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICI AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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5 000 Initial Comments			5 000				
In accord 144.56 at 144.653, pursuant found that herein are not corrected with a sol the Minner at indicated several it items will Lack of citem of massessm violated corrected. You may that may orders provided the Depanotice of On 11/3/2 was condinced in complication. The follow SUBSTA	ance with nd/or Minr this corre to a surve to a surve the defice not corrected shall nedule of esota Departion of what requires ents of the below. Weems, failube considered the considered the form ovided the request a result from the luring the lucted. You ance with napter 466 cilities (St. wing compared to the compared to the considered the considered the lucted to the lucted the lucted to	plaints were found to be	5 000				

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

TITLE (X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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IXLIVITIL	MINEFIN INC WILLIAM	EDINA, MI	N 55436			
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5 000	Continued From page 1		5 000			
	When corrections a date, make a copy of electronically return susie.haben@state	to:				
5 815	MN Statute 626.557	7 Subd. 3. VA Timing of report.	5 815			
	believe that a vulne been maltreated, or vulnerable adult has which is not reason immediately report common entry point vulnerable adult sol admitted to a facility required to report solindividual that occur unless: (1) the individual was another facility and reason to believe the maltreated in the procession of the procession of this section 6 clause (4). (b) A person not recomprovisions of this section 6 clause (4). (c) Nothing in this section of this section of the provisions of the provisions of this section of the provisions of the provisions of this section of the provisions of the provisions of this section of the provisions of the provisions of this section of the provisions of the provis	the information to the t. If an individual is a ely because the individual is a, a mandated reporter is not uspected maltreatment of the rred prior to admission, as admitted to the facility from the reporter has be vulnerable adult was revious facility; or ws or has reason to believe a vulnerable adult as 26.5572, subdivision 21, quired to report under the rection may voluntarily				

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Minnesota Department of Health STATE FORM

XR3C11 If continuation sheet 2 of 5

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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	(5), occurred must subdivision. If the rebelieves that an invivil determine or shareported error was criteria under section paragraph (c), claus may provide to the to the lead agency event meets the crisubdivision 17, parallead agency shall compare the compared to the lead agency shall compared to the lead agen	on 17, paragraph (c), clause make a report under this eporter or a facility, at any time restigation by a lead agency would determine that the not neglect according to the on 626.5572, subdivision 17, se (5), the reporter or facility common entry point or directly information explaining how the teria under section 626.5572, agraph (c), clause (5). The onsider this information when sposition of the report under					
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of client to client abuse immediately to the state agency (SA) for 1 of 3 clients (C1) who was being physically abused by another client.						
	Findings include:						
	C1's Identification Sheet (undated) indicated client diagnoses of severe mental retardation (MR) and Down's syndrome. In a review of C1's records, Individual Abuse Prevention Assessment (IAPP) dated 12/14/20, indicated C1 would not be able to distinguish all physical abuse or defend himself against all physical abuse causing an increase to his vulnerability in this area.						
	client diagnoses of autism and attentio (ADHS). In a review	Sheet (undated) indicated severe to moderate MR, n deficit hyperactivity disorder v of C2's records, IAPP dated C2 may become physically					

Minnesota Department of Health

STATE FORM KR3C11 If continuation sheet 3 of 5

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		5100 WILL		STATE, ZIP CODE		
REM HE	NNEPIN INC WILLIAN	EDINA, M	N 55436			
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5 815	aggressive towards attempting to comm C2 is told to not do physically aggressive around him. Other to aggression when Che may grab staff's arm. C2 did have a lincident report date receiving a report of it was discovered reprevious report that aggressed towards 9/3/21, 9/4/21, 9/30 10/11/21. An intermal When interviewed director (AD) stated to the state agency knowing. AD stated management of about make a report to the been educated on when interviewed of quality improvement events were discovistated any abuse in the state agency righten educated on these incidents were linear events were discovistated any abuse in the state agency righten educated on these incidents were linear events were discovistated any abuse in the state agency righten educated on these incidents were linear events were discovistated any abuse in the state agency righten educated on the state agency righten educated on the state agency righten educated any abuse in the state agency righten educated on the state agency righten educated any abuse in the state agency righten educated on the state ag	s others when he would be nunicate his wants or needs. If something he would become we towards staff or others times he may display physical 22 wants to communicate and hand and drag them by the history of pinching as well. 2d 10/27/21, indicated, "After on 10/26/21 in regards to [C2], eviewing shift notes for the t C2 held or physically [C1] on the following dates: 1/21, 10/2/21, 10/3/21, and hal review had been initiated." 2n 11/4/21, at 10:02 a.m. area of these incidents were reported late due to management not distaff were to inform use, then management would be state. AD stated staff had when to report abuse. 2n 11/4/21, at 10:20 a.m. at specialist (QIS) stated these ered upon record review. QIS incidents would be reported to ght away. QIS stated staff had reporting requirements after re reported. 3cility's policy, entitled: 1 (revised 8/20/18) indicated were to be reported to the strator and State agency	5 815			
	TIME PERIOD FOR	R CORRECTION: Twenty-one				

Minnesota Department of Health

STATE FORM KR3C11 If continuation sheet 4 of 5

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	l l	(X3) DATE SURVEY COMPLETED						
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
REM HENNEPIN INC WILLIAM 5100 WILLIAM AVE EDINA, MN 55436								
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AFT DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE						
5 815 Continued From page 4 (21) days.								

Minnesota Department of Health

STATE FORM KR3C11 If continuation sheet 5 of 5

PRINTED: 11/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L' IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
	24G200		B. WING			C 11/04/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	11/0	<u> 14/202 I</u>
REM HEI	NNEPIN INC WILLIAM	1		5100 WILLIAM AVE EDINA, MN 55436			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD ICED TO THE APPROPI EFICIENCY)	BE	(X5) COMPLETION DATE
W 000	INITIAL COMMEN	гѕ	w c	00			
W 153	completed at your finvestigation. Your with 42 CFR Part 4 Intermediate Care Intellectual Disability. The following compsubstantial Substantial Education of the following compsubstantial Education of the facility must endicate that substantial Education of the facility must endicate the facility facility to the officials in accordance stablished proced. This STANDARD in Based on interview facility failed to repeat the failed the	plaints were found to be 20078040), with a deficiency acceptable electronic POC, an ir facility may be conducted to intial compliance with the en attained. NT OF CLIENTS (2) Insure that all allegations of ect or abuse, as well as a source, are reported administrator or to other ince with State law through	W 1	53			
L ABORATOR)	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING	1, ,	(X3) DATE SURVEY COMPLETED	
						С	
		24G200	B. WING			/04/2021	
NAME OF PROVIDER OR SUPPLIER REM HENNEPIN INC WILLIAM				STREET ADDRESS, CITY, STATE, ZIP CO 5100 WILLIAM AVE EDINA, MN 55436	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5 COMPLE		
W 153	(MR) and Down's records, Individua (IAPP) dated 12/1 able to distinguish himself against all increase to his vull C2's Identification client diagnoses of autism and attenti (ADHS). In a review 4/21/21, indicated aggressive toward attempting to com C2 is told to not dophysically aggression when he may grab stafff arm. C2 did have Incident report data receiving a report it was discovered previous report the aggressed toward 9/3/21, 9/4/21, 9/3 10/11/21. An interviewed director (AD) state to the state agency knowing. AD state management of a make a report to the en educated on When interviewed director when interviewed director when interviewed director to the state agency knowing. AD state management of a make a report to the en educated on when interviewed director when interviewed director when interviewed director to the state agency when interviewed director whe	syndrome. In a review of C1's Abuse Prevention Assessment 4/20, indicated C1 would not be all physical abuse or defend physical abuse causing an nerability in this area. Sheet (undated) indicated of severe to moderate MR, on deficit hyperactivity disorder the word C2's records, IAPP dated C2 may become physically also others when he would be municate his wants or needs. If the something he would become sive towards staff or others of times he may display physical C2 wants to communicate and shand and drag them by the an history of pinching as well. Sted 10/27/21, indicated, "After on 10/26/21 in regards to [C2], reviewing shift notes for the late C2 held or physically as [C1] on the following dates: 10/21, 10/2/21, 10/3/21, and on 11/4/21, at 10:02 a.m. area and these incidents were reported by late due to management not led staff were to inform the buse, then management would he state. AD stated staff had when to report abuse. On 11/4/21, at 10:20 a.m. area and the state. AD stated staff had when to report abuse.	W 1	153			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24G200	B. WING _			C / 04/2021		
NAME OF PROVIDER OR SUPPLIER REM HENNEPIN INC WILLIAM				STREET ADDRESS, CITY, STATE, ZIP CODE 5100 WILLIAM AVE EDINA, MN 55436				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
W 153	events were discov stated any abuse in the state agency rig been educated on r these incidents wer In a review of the fa Vulnerable Adult 5.2 all forms of abuse v	ered upon record review. QIS acidents would be reported to ght away. QIS stated staff had reporting requirements after	W 15	53				