DEPARTMENT OF HEALTH

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:

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 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
	24G200	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HENNEPIN INC WILLIAM	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On 11/3/21 - 11/4/21, an abbreviated survey was completed at your facility to conduct a complaint 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 found to be SUBSTANTIATED: HG200016C (MN00078040), with no deficiency cited. However, as a result of the investigation, a deficiency was cited at W153. 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 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 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:	W 153		

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

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W 153	Continued From page 1	W 153		

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.

C2's Identification Sheet (undated) indicated client diagnoses of severe to moderate MR, autism and attention deficit hyperactivity disorder (ADHS). In a review of C2's records, IAPP dated 4/21/21, indicated C2 may become physically aggressive towards others when he would be attempting to communicate his wants or needs. If C2 is told to not do something he would become physically aggressive towards staff or others around him. Other times he may display physical aggression when C2 wants to communicate and he may grab staff's hand and drag them by the arm. C2 did have a history of pinching as well.

Incident report dated 10/27/21, indicated, "After receiving a report on 10/26/21 in regards to [C2], it was discovered reviewing shift notes for the previous report that C2 held or physically aggressed towards [C1] on the following dates: 9/3/21, 9/4/21, 9/30/21, 10/2/21, 10/3/21, and 10/11/21. An internal review had been initiated."

When interviewed on 11/4/21, at 10:02 a.m. area director (AD) stated these incidents were reported to the state agency late due to management not knowing. AD stated staff were to inform management of abuse, then management would make a report to the state. AD stated staff had been educated on when to report abuse.

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W 153	Continued From page 2 When interviewed on 11/4/21, at 10:20 a.m. quality improvement specialist (QIS) stated these events were discovered upon record review. QIS stated any abuse incidents would be reported to the state agency right away. QIS stated staff had been educated on reporting requirements after these incidents were reported. In a review of the facility's policy, entitled: Vulnerable Adult 5.1 (revised 8/20/18) indicated all forms of abuse were to be reported to the designated administrator and State agency immediately.	W 153		

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W 000	received 11/24/21 approved 12/1/21 Susie Haven INITIAL COMMENTS On 11/3/21 - 11/4/21, an abbreviated survey was completed at your facility to conduct a complaint 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 found to be SUBSTANTIATED: HG200016C (MN00078040), with no deficiency cited. However, as a result of the investigation, a deficiency was cited at W153. 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	**W153** 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 the other officials in accordance with State law through established procedures. Any staff deficient in training will be trained on Policy 5.1 (Vulnerable Adult Reporting), as well as Policy 12.1 (Administrative Review of Incidents) in regards to immediate reporting for incidents including peer to peer physical aggression or any other actions that could be perceived as maltreatment/neglect. In addition, all staff will be trained using a document outlining examples and specific situations which staff would need to report based on the previously completed review of shift note documentation and incident reports.	12/3/21
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 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:	W 153	A review of shift notes and incident reports by the QIDP/Quality Improvement will occur on a weekly basis for a period of 1 month, and if no issues, a review of shift notes and incident reports will occur on a regular basis to ensure that all relevant reports are made in a timely manner according to policy. Ongoing, all incidents of potential allegations of abuse/neglect will be reported immediately to the designated state. The corrections are implemented by the QIDP and will be monitored by the Area Director. **Completion Date:** 12/3/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Rodwell — TITLE: Regional Director — (X6) DATE: 11/24/21

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 153	Continued From page 1 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. C2's Identification Sheet (undated) indicated client diagnoses of severe to moderate MR, autism and attention deficit hyperactivity disorder (ADHS). In a review of C2's records, IAPP dated 4/21/21, indicated C2 may become physically aggressive towards others when he would be attempting to communicate his wants or needs. If C2 is told to not do something he would become physically aggressive towards staff or others around him. Other times he may display physical aggression when C2 wants to communicate and he may grab staff's hand and drag them by the arm. C2 did have a history of pinching as well. Incident report dated 10/27/21, indicated, "After receiving a report on 10/26/21 in regards to [C2], it was discovered reviewing shift notes for the previous report that C2 held or physically aggressed towards [C1] on the following dates: 9/3/21, 9/4/21, 9/30/21, 10/2/21, 10/3/21, and 10/11/21. An internal review had been initiated." When interviewed on 11/4/21, at 10:02 a.m. area director (AD) stated these incidents were reported to the state agency late due to management not knowing. AD stated staff were to inform management of abuse, then management would make a report to the state. AD stated staff had been educated on when to report abuse.	W 153		

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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:

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
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
	01149	A. BUILDING: _____ B. WING _____	C 11/04/2021

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REM HENNEPIN INC WILLIAM	5100 WILLIAM AVE EDINA, MN 55436

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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 11/3/21 - 11/4/21, a complaint investigation 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 found to be SUBSTANTIATED: HG200016C (MN00078040), with licensing orders issued.	5 000		

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5 000	Continued From page 1 When corrections are completed, please sign and date, make a copy of these orders and electronically return to: susie.haben@state.mn.us	5 000		
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section	5 815		

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5 815	Continued From page 2	5 815		

626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.

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.

C2's Identification Sheet (undated) indicated client diagnoses of severe to moderate MR, autism and attention deficit hyperactivity disorder (ADHS). In a review of C2's records, IAPP dated 4/21/21, indicated C2 may become physically

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5 815	Continued From page 3	5 815		

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Incident report dated 10/27/21, indicated, "After receiving a report on 10/26/21 in regards to [C2], it was discovered reviewing shift notes for the previous report that C2 held or physically aggressed towards [C1] on the following dates: 9/3/21, 9/4/21, 9/30/21, 10/2/21, 10/3/21, and 10/11/21. An internal review had been initiated."

When interviewed on 11/4/21, at 10:02 a.m. area director (AD) stated these incidents were reported to the state agency late due to management not knowing. AD stated staff were to inform management of abuse, then management would make a report to the state. AD stated staff had been educated on when to report abuse.

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In a review of the facility's policy, entitled: Vulnerable Adult 5.1 (revised 8/20/18) indicated all forms of abuse were to be reported to the designated administrator and State agency immediately.

TIME PERIOD FOR CORRECTION: Twenty-one

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5 815	Continued From page 4 (21) days.	5 815		

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W 000	INITIAL COMMENTS On 11/3/21 - 11/4/21, an abbreviated survey was completed at your facility to conduct a complaint 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 found to be SUBSTANTIATED: HG200016C (MN00078040), with a deficiency cited at W153. 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 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 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	W 153		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G200	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HENNEPIN INC WILLIAM	**5100 WILLIAM AVE EDINA, MN 55436**

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W 153	Continued From page 1	W 153		

(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.

C2's Identification Sheet (undated) indicated client diagnoses of severe to moderate MR, autism and attention deficit hyperactivity disorder (ADHS). In a review of C2's records, IAPP dated 4/21/21, indicated C2 may become physically aggressive towards others when he would be attempting to communicate his wants or needs. If C2 is told to not do something he would become physically aggressive towards staff or others around him. Other times he may display physical aggression when C2 wants to communicate and he may grab staff's hand and drag them by the arm. C2 did have a history of pinching as well.

Incident report dated 10/27/21, indicated, "After receiving a report on 10/26/21 in regards to [C2], it was discovered reviewing shift notes for the previous report that C2 held or physically aggressed towards [C1] on the following dates: 9/3/21, 9/4/21, 9/30/21, 10/2/21, 10/3/21, and 10/11/21. An internal review had been initiated."

When interviewed on 11/4/21, at 10:02 a.m. area director (AD) stated these incidents were reported to the state agency late due to management not knowing. AD stated staff were to inform management of abuse, then management would make a report to the state. AD stated staff had been educated on when to report abuse.

When interviewed on 11/4/21, at 10:20 a.m. quality improvement specialist (QIS) stated these

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W 153	Continued From page 2 events were discovered upon record review. QIS stated any abuse incidents would be reported to the state agency right away. QIS stated staff had been educated on reporting requirements after these incidents were reported. In a review of the facility's policy, entitled: Vulnerable Adult 5.1 (revised 8/20/18) indicated all forms of abuse were to be reported to the designated administrator and State agency immediately.	W 153		