Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

July 17, 2025

Administrator
Living Well France
2759 France Avenue North
Robbinsdale, MN 55422-3735

RE: Event ID: 0XQ911

Dear Administrator:

On July 1, 2025, an abbreviated survey was completed at your facility by the Minnesota Department of Health 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 electronically 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). **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.

Failure to submit an acceptable written plan of correction for all Health Federal deficiencies within ten calendar days may result in additional remedies and/or decertification including a loss of federal reimbursement.

Your PoC must include:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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.

DEPARTMENT CONTACT:

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, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G295	A. BUILDING _____ B. WING _____	C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL FRANCE	2759 FRANCE AVENUE NORTH ROBBINSDALE, MN 55422

(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 6/30/25 and 7/01/25, a standard abbreviated survey was completed at your facility to conduct a complaint(s) 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 complaint was reviewed HG2958170C (MN11480) with a deficiency issued at W144. Additionally, deficiencies were issued as a result of the investigation at W149, W153 and W154. 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 144	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(2) The facility must answer communications from clients' families and friends promptly and appropriately. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to respond timely to a family inquiry for 1 of 1 (C1) clients reviewed communication. Findings include: C1's Emergency Data Form dated 1/25/24, indicated C1 had moderate intellectual disability. During interview on 7/01/25 at 8:05 a.m., C1's Case Manager (CM) stated she emailed the	W 144		

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 144	Continued From page 1 facility about C1's bruise and there been no follow up. in addition, the CM stated C1's family (FM)-A had asked the assistance program manager (APM)-A about the bruise, which they described as purple and large, "bigger than a silver dollar". Additionally, CM added FM-A indicated APM-A stated he would check the records and get back with them and never did. CM-A stated there was overall a lack of communication, which was frustrating since the FM-A first noticed the bruise on 6/23/25, and they were still waiting for follow up. During interview on 7/01/25 at 11:40 a.m., APM-A stated FM-A was walking out the door when they mentioned the bruising and APM-A stated he had not checked C1 for bruising, followed up with the family, contacted his supervisor or SA. Additionally, no GED was completed. APM-A added, he assumed if C1 had a bruise it was due to her self-injurious behavior. During interview on 7/01/25 at 11:50 a.m., regional director stated, APM-A should have informed the program manager of the bruising after he was made aware and it should have been reported if abuse was suspected or alleged abuse or was an injury of unknown origin. Lastly, an investigation should have been started and the team should have been followed up with.	W 144		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview and document	W 149		

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W 149	Continued From page 2 review, the facility failed to implement abuse policies related to injury of unknown origin for 1 of 1 client (C1) who was observed to have a bruise. Findings include: C1's Emergency Data Form dated 1/25/24, indicated C1 had moderate intellectual disability.. During interview on 6/30/25 at 12:47 p.m., assistant program manager (APM)-B stated he worked the evening shift and on the weekend of the incident C1 had some behavioral episodes, displaying some screaming and throwing herself on the floor. Direct support staff (DSP)-A tried to get near C1, and C1 continued to call out C2's name and C2 does not like her name called out. APM-B stated there was no bruising noted on C1, but noted C1's family had reported a bruise. APM-B stated FM-A was walking out the door when she mentioned the bruising on C1's right arm and did not look at her arm. C1 left with FM-A for a couple of days and when she returned he did not notice any bruising. During observation on 6/30/25 at 1:17 p.m., seven days after the alleged incident of bruising with APM-B who was observed to remove C1's shirt there was an left outer arm bruise noted dime sized purple in color. APM-B stated C1 could have caused the bruise due to self-injuries behavior. During interview on 7/01/25 at 8:05 a.m., C1's Case Manager (CM) stated she emailed the facility about C1's bruise and there had been no follow up. In addition, the CM stated C1's family (FM)-A had asked the assistance program manager (APM)-A about the bruise, which they	W 149		

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W 149	Continued From page 3 described as purple and large, "bigger than a silver dollar". Additionally, CM added FM-A indicated APM-A stated he would check the records and get back with them and never had. Interview on 7/01/25 at 11:40 a.m., APM-A stated FM-A was walking out the door when they mentioned the bruising and he had not check C1 for bruising, followed up with the family, contacted his supervisor or State Agency. Additionally, no GED was completed. APM-A added, he assumed if C1 had a bruise it was due to her self-injurious behavior. During interview on 7/01/25 at 11:50 a.m., regional director stated, although C1 does have a history of self-injurious behaviors, which is not currently reflected in her program plans but will be added, the APM-A should have informed the program manager of the bruising after he was made aware and it should have been reported if abuse was suspected or alleged or was an injury of unknown origin. Lastly, an investigation should have been started. Incident Response, Reporting and Review Policy revised 2/18/25, indicated if the program is an ICF/DD, a report of the death or serious injury of a person must also be reported to the both the Office of Ombudsman, Department of Human Services Licensing Division, and Office of Health Facility Complaints immediately. If maltreatment is suspected surrounding the death or serious injury, Minnesota Adult Abuse Reporting Center (MAARC) must be notified.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)	W 153		

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W 153	Continued From page 4 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 record review the facility failed to report an injury of unknown origin to the State Agency (SA) for 1 of 1 (C1) clients when reviewed for abuse. Findings include: C1's Emergency Data Form dated 1/25/24, indicated C1 had moderate intellectual disability. During interview on 7/01/25 at 8:05 a.m., C1's Case Manager (CM) stated she emailed the facility about C1's bruise and there had been no follow up. in addition, the CM stated C1's family (FM)-A had asked the assistance program manager (APM)-A about the bruise, which they described as purple and large, "bigger than a silver dollar". Additionally, CM added FM-A indicated APM-A stated he would check the records and get back with them and never had. Interview on 7/01/25 at 11:40 a.m., APM-A stated FM-A was walking out the door when they mentioned the bruising and APM-A stated he had not check C1 for bruising, followed up with the family, contacted his supervisor or SA. Additionally, no GED was completed. APM-A added, he assumed if C1 had a bruise it was due to her self-injurious behavior. During interview on 7/01/25 at 11:50 a.m., regional director stated, although C1 does have a	W 153		

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W 153	Continued From page 5 history of self-injurious behaviors, which is not currently reflected in her program plans but will be added, the APM-A should have informed the program manager of the bruising after he was made aware and it should have been reported if abuse was suspected or alleged or was an injury of unknown origin. Lastly, an investigation should have been started. Incident Response, Reporting and Review Policy revised 2/18/25, indicated if the program is an ICF/DD, a report of the death or serious injury of a person must also be reported to the both the Office of Ombudsman, Department of Human Services Licensing Division, and Office of Health Facility Complaints immediately. If maltreatment is suspected surrounding the death or serious injury, Minnesota Adult Abuse Reporting Center (MAARC) must be notified.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to investigate an injury of unknown origin for 1 of 1 (C1) client who had a large bruise reported by family. Findings include: C1's Emergency Data Form dated 1/25/24, indicated C1 had moderate intellectual disability. During interview on 7/01/25 at 8:05 a.m., C1's Case Manager (CM) stated she emailed the facility about C1's bruise and there had been no	W 154		

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W 154	Continued From page 6 follow up. In addition, the CM stated C1's family (FM)-A had asked the assistance program manager (APM)-A about the bruise, which they described as purple and large, "bigger than a silver dollar". Additionally, CM added FM-A indicated APM-A stated he would check the records and get back with them and never had. Interview on 7/01/25 at 11:40 a.m., APM-A stated FM-A was walking out the door when they mentioned the bruising and APM-A stated he had not check C1 for bruising, followed up with the family, contacted his supervisor or State Agency. Additionally, no GED was completed. APM-A added, he assumed if C1 had a bruise it was due to her self-injurious behavior. During interview on 7/01/25 at 11:50 a.m., regional director stated, although C1 does have a history of self-injurious behaviors, which is not currently reflected in her program plans but will be added, the APM-A should have informed the program manager of the bruising after he was made aware and it should have been reported if abuse was suspected or alleged or was an injury of unknown origin. Lastly, an investigation should have been started. Incident Response, Reporting and Review Policy revised 2/18/25, indicated if the program is an ICF/DD, a report of the death or serious injury of a person must also be reported to the both the Office of Ombudsman, Department of Human Services Licensing Division, and Office of Health Facility Complaints immediately. If maltreatment is suspected surrounding the death or serious injury, Minnesota Adult Abuse Reporting Center (MAARC) must be notified.	W 154		

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July 17, 2025

Administrator
Living Well France
2759 France Avenue North
Robbinsdale, MN 55422-3735

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: 0XQ911

Dear Administrator:

The above facility was surveyed on June 30, 2025 through July 1, 2025 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.

The first page of the state orders should be signed and submitted along with your federal plan of correction to:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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 the supervisor listed above. A written plan for correction of licensing orders is not required.

You may request reconsideration of this correction order within 15 calendar days of receipt of this order. To submit a reconsideration, please visit: https://forms.web.health.state.mn.us/form/HRDAppealsForm.

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

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01290	A. BUILDING: _____ B. WING _____	C 07/01/2025

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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 6/30/25 through 7/01/25, a standard abbreviated survey 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 complaint was reviewed: HG2958170C (MN11480) with no licensing orders issued.	5 000		

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5 000	Continued From page 1 As a result of the investigation, a licensing order was issued at 0815. 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	5 815		

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5 815	Continued From page 2 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 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 record review the facility failed to report an injury of unknown origin to the State Agency (SA) for 1 of 1 (C1) clients when reviewed for abuse. Findings include: C1's Emergency Data Form dated 1/25/24, indicated C1 had moderate intellectual disability. During interview on 7/01/25 at 8:05 a.m., C1's Case Manager (CM) stated she emailed the facility about C1's bruise and there had been no follow up. in addition, the CM stated C1's family (FM)-A had asked the assistance program manager (APM)-A about the bruise, which they described as purple and large, "bigger than a silver dollar". Additionally, CM added FM-A	5 815		

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LIVING WELL FRANCE	2759 FRANCE AVENUE NORTH ROBBINSDALE, MN 55422

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5 815	Continued From page 3 indicated APM-A stated he would check the records and get back with them and never had. Interview on 7/01/25 at 11:40 a.m., APM-A stated FM-A was walking out the door when they mentioned the bruising and APM-A stated he had not check C1 for bruising, followed up with the family, contacted his supervisor or SA. Additionally, no GED was completed. APM-A added, he assumed if C1 had a bruise it was due to her self-injurious behavior. During interview on 7/01/25 at 11:50 a.m., regional director stated, although C1 does have a history of self-injurious behaviors, which is not currently reflected in her program plans but will be added, the APM-A should have informed the program manager of the bruising after he was made aware and it should have been reported if abuse was suspected or alleged or was an injury of unknown origin. Lastly, an investigation should have been started. Incident Response, Reporting and Review Policy revised 2/18/25, indicated if the program is an ICF/DD, a report of the death or serious injury of a person must also be reported to the both the Office of Ombudsman, Department of Human Services Licensing Division, and Office of Health Facility Complaints immediately. If maltreatment is suspected surrounding the death or serious injury, Minnesota Adult Abuse Reporting Center (MAARC) must be notified. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 815		