DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

March 14, 2022

Administrator
Careco Apartments
6115 Carmen Avenue East
Inver Grove Heights, MN 55076

RE: Event ID: TKZI11

Dear Administrator:

On March 4, 2022, 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. This survey found one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the survey we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the electronically delivered "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy effective March 4, 2022.

One or more of these deficiencies do not meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID):

W158 42 CFR § 483.430 - Facility Staffing

Federal certification deficiencies are delineated on the enclosed 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 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 correctionk 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.

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by April 28, 2022, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G422	A. BUILDING _____ B. WING _____	C 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO APARTMENTS	**6115 CARMEN AVENUE EAST INVER GROVE HEIGHTS, MN 55076**

(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 3/1/22 - 3/4/22, 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. 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 compliance with deficiencies issued at W508. The following complaints were found to be SUBSTANTIATED with a deficiency at W508. HG422002C (MN80468) The following complaints were found to be UNSUBSTANTIATED with no deficiencies cited. HG422003C (MN71978) The Condition of Participation: Facility Staffing 42 CFR 483.430 was found not to be met. An Immediate Jeopardy (IJ) was identified at W508 on 3/1/22, at 4:00 p.m. The IJ began on 1/27/22, when the facility failed to have a 100% staff vaccination rate (current vaccinated rate was 56.3% and unvaccinated rate was 43.7%) and failed to wear appropriate PPE (surgical masks, eye protection) in client care areas to reduce the spread of COVID-19. The administrator was informed of the IJ on 3/1/22, at 4:00 p.m. The immediate jeopardy was removed on 3/4/22, at 11:25 a.m. when the facility's approved removal plan was verified onsite by the	W 000		

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

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W 000	Continued From page 1 state agency. 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 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the The Condition of Participation: Facility Staffing 42 CFR 483.430 was not met. Findings include: See W508: The facility failed to develop and implement policies and procedures regarding staff vaccination and did not ensure 100% of staff were either fully vaccinated, granted a qualifying exemption, or had a temporary delay. The facility's current vaccination rate was 56.3%, with 43.7% of staff remaining unvaccinated without having exemptions and failed to ensure the use of required personal protective equipment (PPE) to protect from the spread of COVID 19. This resulted in an immediate jeopardy.	W 158		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of	W 508		

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W 508	Continued From page 2 this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for	W 508		

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W 508	Continued From page 3 whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all	W 508		

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W 508	Continued From page 4 applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop and implement policies and procedures regarding staff	W 508		

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W 508	Continued From page 5 vaccination and did not ensure 100% of staff were either fully vaccinated, exempt, or had a temporary delay. In addition, the facility failed to implement appropriate Personal Protective Equipment (PPE) use during direct client care observations for 5 of 13 clients (C1, C2, C3, C4, C5) in the home. This resulted in an immediate jeopardy. The IJ began on 1/27/22, when the facility failed to have a 100% staff vaccination rate (current vaccinated rate was 56.3% and unvaccinated rate was 43.7%) and failed to wear appropriate PPE (surgical masks, eye protection) in client care areas to reduce the spread of COVID-19. The administrator was informed of the IJ on 3/1/22, at 4:00 p.m. The immediate jeopardy was removed on 3/4/22, at 11:25 a.m. when the facility's approved removal plan was verified onsite by the state agency. Findings include: C1's face sheet reviewed 3/4/22, indicated C1's diagnosis included moderate intellectual disability. C2's face sheet reviewed 3/4/22, indicated C2's diagnosis included moderate intellectual disability. C3's face sheet reviewed 3/4/22, indicated C3's diagnosis included mild intellectual disability and cerebral palsy. C4's face sheet reviewed 3/4/22, indicated C4's diagnosis included mild intellectual disability and type 2 diabetes. C5's face sheet reviewed 3/4/22, indicated C5's diagnosis included severe intellectual disability,	W 508		

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W 508	Continued From page 6 Tourette's syndrome, and autism. Facility provided COVID-19 Vaccination Matrix indicated the facility's current vaccination rate was 56.3%, with 43.7% of staff remaining unvaccinated. 6 staff were unvaccinated and did not have exemptions or delays per CMS guidelines. When observed on 3/1/22, at 9:00 a.m. DSP-A entered the facility wearing a surgical mask with no eye protection in place. When observed on 3/1/22, at 9:30 a.m. DSP-C exited the floor with clients and entered the staff office with no mask or eye protection in place. DSP-C gathered her belongings and exited the facility through the common living room with no PPE in place. When observed on 3/1/22, at 9:51 a.m. DSP-B entered the facility with no mask or eye protection in place. DSP-B stopped in the hallway and spoke with C5 within two feet, for approximately two minutes. When observed on 3/1/22, from 10:03 a.m. to 10:18 a.m. DSP-A and DSP-B were observed in the apartment of C2, C3 and C4 cleaning, conversing, and interacting within six feet of the clients repeatedly without use of eye protection. When observed on 3/1/22, at 10:18 a.m. DSP-B sat at the common room table within two feet of C5 and assisted C5 with a puzzle for approximately two minutes without use of eye protection. When observed on 3/1/22, at 2:11 p.m. DSP-D	W 508		

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W 508	Continued From page 7 entered the facility with no mask or eye protection in place and went into the staff office. At 2:14 p.m. DSP-D exited the staff office wearing a surgical mask and eye protection on top of his head. At 2:15 p.m. DSP-D entered the medication room and prepared medications, at 2:16 p.m. DSP-D appropriately placed eye protection and proceeded with medication pass. When interviewed on 3/1/22, at 9:05 a.m. DSP-A stated there had been a COVID-19 outbreak at the facility in January affecting both clients and staff and DSP-A herself became positive she believed after exposure to positive clients without appropriate PPE being made available. DSP-A stated she was aware of several staff who were not vaccinated. DSP-A stated N95 masks, gowns, and gloves were not provided during the outbreak. Face shields were provided but not required to be worn. DSP-A stated presently, facemasks were "optional" and most staff did not utilize masks and she had not been directed to use eye protection during client interactions. When interviewed on 3/1/22, at 9:26 a.m. licensed practical nurse (LPN)-A verified she was the facility infection control nurse and stated she was not aware that staff vaccination was a CMS mandate. RN-A stated she believed almost 100% of staff were vaccinated but had not been aware of or started exemptions for unvaccinated staff. RN-A stated she was not aware of QSO memos or other resources regarding the vaccine directive and had no policies regarding this. RN-A verified there were staff and resident COVID outbreaks in January and stated as a small facility, she did not have time to remain up to date on CMS guidelines.	W 508		

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W 508	Continued From page 8 When interviewed on 3/1/22, at 10:27 a.m. house manager (HM)-A stated she was not aware of the vaccine mandate as they are a small independent facility and are unsure how to remain up to date on CMS guidance. HM-A verified the facility had no policies or procedures in place regarding staff vaccination. HM-A verified unvaccinated staff did not have exemptions. HM-A further stated right now because we don't have the outbreak it is up to staff whether they want to use eye protection. HM-A stated she was aware Dakota county was in a substantial outbreak status and the CDC guidance on eye protection was "just a recommendation" and that is what we always have told staff. When interviewed on 3/1/22, at 10:46 a.m. DSP-B stated a while ago when COVID first started staff were instructed to always wear eye protection, but after quarantine ended staff "backed off" on wearing eye protection and use was not being enforced. DSP-B verified mask use was presently optional for staff, and stated staff were informed if there are less than 100 staff in the facility masks were not required. DSP-B stated eye protection was available. DSP-B verified the facility had face shields, goggles, surgical masks, and N95 masks presently available, although staff were not fit-tested for N95 use. When interviewed on 3/1/22, at 2:47 p.m. DSP-D stated he was unvaccinated and had not been asked to complete an exemption form. He was not aware of any additional precautions he needed to use due to his being unvaccinated. DSP-D stated he was not instructed to use additional PPE and was only tested when there was suspected COVID in the building, or tested	W 508		

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W 508	Continued From page 9 monthly, and that had not changed due to his vaccination status. He stated staff have been directed to wear a surgical mask and eye protection when in the facility and had been educated on infection control practices. Facility policy titled COVID 19 Preparedness Plan 2020 lacked direction for use of eye protection and did direct staff to wear a face mask. The policy contained no guidance regarding staff vaccination. The immediate jeopardy that began on 1/27/22, was removed on 3/4/22, when verified through interview, observation and record review the facility conducted training for all staff on appropriate PPE use, vaccination/exemption requirements, created and obtained exemption forms for 6 of 6 unvaccinated staff, a policy was developed regarding staff vaccinations and exemptions, and the facility COVID-19 policy was updated to reflect use of universal eye protection and PPE.	W 508		

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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 3/1/22 - 3/4/22, 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 complaints were found to be SUBSTANTIATED with no licensing orders issued: HG422002C (MN80468)	5 000		

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5 000	Continued From page 1 The following complaints were found to be UNSUBSTANTIATED with no licensing orders issued: HG422003C (MN71978)	5 000		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 14, 2022

Administrator
Careco Apartments
6115 Carmen Avenue East
Inver Grove Heights, MN 55076

Re: PEvent ID: TKZI11

Dear Administrator:

The above facility survey was completed on March 4, 2022 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