

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

January 26, 2022

Administrator
People II
1380 West Minnehaha Parkway
Minneapolis, MN 55419

RE: Event ID: J0V011

Dear Administrator:

On January 12, 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.

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):

W0318 42 CFR § 483.460 Health Care Services

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.

People Ii January 26, 2022 Page 2

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 March 8, 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, Health Program Representative Senior Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Kim Tyson

Saint Paul, Minnesota 55164-0970

Phone: 651-201-3831

Email: kim.tyson@state.mn.us

cc: Licensing and Certification File

PRINTED: 01/26/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION		E SURVEY PLETED
		24G435	B. WING				C
NAME OF S	200//050 00 01/001/50	240433	D. WING			01/	12/2022
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PEOPLE	II				1380 WEST MINNEHAHA PARKWAY		
				ı	MINNEAPOLIS, MN 55419		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
TAG	REGULATORT OR E	SCIDENTII TING INI CHWATION)	IAG		DEFICIENCY)	MAIL	
			i				
W 000		T.O.	\ \\ \\ \	200			
W 000	INITIAL COMMENT	15	W C	JUU			
		h 1/12/22, an abbreviated					
		ted to investigate a complaint.					
		nd NOT to be in compliance					
		nts of 42CFR 483 Subpart I,					
		re Facilities for Individuals					
	with Intellectual Dis	abilities (ICF/IID).					
	The following comp	plaint below was found to be					
		35024C (MN79743) with					
	deficiencies issued						
	4011010110100 100404	ut 11001.					
	The Condition of Pa	articipation: Health Care					
	Services 483.460 w						
W 318	HEALTH CARE SE	RVICES	W 3	318	3		
	CFR(s): 483.460						
		sure that specific health care					
	services requireme	nts are met.					
	This CONDITION	is not met as suideneed by					
		is not met as evidenced by:					
		v and document review, the pation at 42 CFR 483.460					
	· ·	es, was not met. The facility					
		equate nursing services to 1 of					
		was leaving the facility on					
		to visit family members for					
		f time and not following					
	physician prescribe						
	, , ,						
	Findings include:						
		cility failed to ensure					
		were followed for 1 of 1 clients					
	(C1). Additionally, t						
	communicate risk v	versus benefit of not following					
LABORATOR	/ DIRECTOR'S OR BROVE	DER/SUPPLIER REPRESENTATIVE'S SIGI	IATLIDE		TITLE		(X6) DATE
PYPOLYIOK.	I DINLOTONO OR PROVIL	JEINGUEFEIEN NEFNEGENTATIVE 3 SIGI	NATURE.		IIILE		(AU) DAIL

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		LE CONSTRUCTION		E SURVEY PLETED
		24G435	B. WING				C 1 2/2022
NAME OF F	PROVIDER OR SUPPLIER		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 318		implement medication ram. ES	w				
	The facility must proservices in accorda This STANDARD is Based on observat review, the facility for (C1) followed physic and prescribed bloc calling the physician to inform client of ris orders and implementationing program for	ovide clients with nursing nce with their needs. It is not met as evidenced by: sion, interview and document ailed to ensure 1 of 1 clients of glucose parameters for the n. Additionally, the failed failed sk vs benefits of not following the medication administration					
	had Diabetes Mellit	neet dated 9/1/21, indicated he us Type 2 and hyperlipidemia of lipids or fat in blood).					
	(CFA) updated 11/2 to understand and redical health and solve insulin by issusteep, etc. impacts	re Functional Assessment (021, indicated C1 was unable retain information related to had limited ability to problem use and understand how food, diabetes. The CFA further ave house without telling staff ons.					
	10/08/21, indicated hypoglycemia (low pressure. The disc	al discharge orders dated he was hospitalized for blood sugar) and low blood harge orders sent to Peoples dicated C1 to be compliant regimen.					

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 331 Continued From page 2 The hospital discharge orders instructed to check his blood glucose four times a day and to contact health care provider if he had the following readings: -Hyperglycemia unexplained glucose readings of 250 milligrams/deciliter (mg/dl) or greater for more than 2 times in the same day. -Hypoglycemia readings of 70 mg/dl or less two times in the same day or three times with in one week. Review of C1's blood glucose readings indicated the following from 10/08/21 to 1/11/22 with no documentation C1's physician was notified of the out of range blood glucose reading son the day it occurred: 10/10/21 blood glucose reading 485 and 402 10/19/21 blood glucose reading 60, 52 and 57 11/1/21 Blood glucose reading 288 and 495 11/10/21 blood glucose reading 288 and 495 11/10/21 blood glucose grading 461 and 403 11/14/21 blood glucose grading 461 and 403 11/14/21 blood glucose reading 51 and 49 12/28/21 blood glucose reading 51 and 49 12/28/21 blood glucose reading 344, 279 and 336 C1's current Physician Orders dated January 2022, indicated C1 received Lantus Solostar 18		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
PEOPLE II STREET ADDRESS, CT.Y, STATE, ZIP CODE 1380 WEST MINNEAPOLIS, MN 55419 (A4) ID PRETRY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETRY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETRY (EACH DORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 331 W 331 Continued From page 2 W 331 W 331 W 331 The hospital discharge orders instructed to check his blood glucose four times a day and to contact health care provider if he had the following readings: -Hyperglycemia unexplained glucose readings of 250 milligrams/deciliter (mg/dl) or greater for more than 2 times in the same dayHypoglycemia readings of 70 mg/dl or less two times in the same day or three times with in one week. Review of C1's blood glucose reading sindicated the following from 10/08/21 to 1/11/122 with no documentation C1's physician was notified of the out of range blood glucose reading 485 and 402 10/19/21 blood glucose reading 288 and 495 11/10/21 blood glucose reading 288 and 495 11/10/21 blood glucose reading 288 and 495 11/10/21 blood glucose reading 317 and 332 1/2/28/21 blood glucose reading 51 and 49 12/28/21 blood glucose reading 317 and 332 1/4/22 blood glucose reading 317 and 332 1/4/22 blood glucose reading 317 and 334 C1's current Physician Orders dated January 2022, indicated C1 received Lantus Solostar 18			24G435	B. WING		01	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 331 Continued From page 2 The hospital discharge orders instructed to check his blood glucose four times a day and to contact health care provider if he had the following readings: -Hyperglycemia unexplained glucose readings of 250 milligrams/deciliter (mg/dl) or greater for more than 2 times in the same dayHypoglycemia readings of 70 mg/dl or less two times in the same day or three times with in one week. Review of C1's blood glucose readings indicated the following from 10/08/21 to 1/11/22 with no documentation C1's physician was notified of the out of range blood glucose reading 485 and 402 10/19/21 blood glucose reading 485 and 402 10/19/21 blood glucose reading 288 and 495 11/10/21 blood glucose reading 288 and 495 11/10/21 blood glucose reading 289 and 302 12/14/21 blood glucose reading 51 and 49 12/28/21 blood glucose reading 317 and 332 1/4/22 blood glucose reading 344, 279 and 346 C1's current Physician Orders dated January 2022, indicated C1 received Lantus Solostar 18				1	1380 WEST MINNEHAHA PARKWAY		TILILOLL
The hospital discharge orders instructed to check his blood glucose four times a day and to contact health care provider if he had the following readings: -Hyperglycemia unexplained glucose readings of 250 milligrams/deciliter (mg/dl) or greater for more than 2 times in the same day. -Hypoglycemia readings of 70 mg/dl or less two times in the same day or three times with in one week. Review of C1's blood glucose readings indicated the following from 10/08/21 to 1/11/22 with no documentation C1's physician was notified of the out of range blood glucose readings on the day it occurred: 10/10/21 blood glucose reading 471,444 and 387 10/14/21 blood glucose reading 485 and 402 10/19/21 blood glucose reading 288 and 495 11/10/21 blood glucose reading 288 and 495 11/10/21 blood glucose reading 259 and 302 12/14/21 blood glucose reading 51 and 49 12/28/21 blood glucose reading 317 and 332 1/4/22 blood glucose reading 344, 279 and 346 C1's current Physician Orders dated January 2022, indicated C1 received Lantus Solostar 18	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	IOULD BE	COMPLETION
units daily in the morning, Humalog Kwikpen 4 units twice daily at lunch and dinner 10 minutes before meal and 6 units in the morning. In addition, C1 received sliding scale Humalog Kwik Pen in addition to scheduled insulin before meals if readings are 0-150- no insulin, 151-199 give 1 unit, 200-249 give 2 units, 250-299 give 3 units.	W 331	The hospital discharcheck his blood glucontact health care following readings: -Hyperglycemia une 250 milligrams/decimore than 2 times in -Hypoglycemia readitimes in the same of week. Review of C1's blood the following from 1 documentation C1's out of range blood goccurred: 10/10/21 blood gluconty/12/12 blood gluconty/12/12 blood gluconty/12/14/21 blood gluconty/14/21 blood gluconty/14/22 blood gluconty	arge orders instructed to cose four times a day and to provider if he had the explained glucose readings of liter (mg/dl) or greater for in the same day. dings of 70 mg/dl or less two lay or three times with in one and glucose readings indicated 0/08/21 to 1/11/22 with no sphysician was notified of the glucose readings on the day it cose reading 471,444 and 387 cose reading 485 and 402 cose reading 60, 52 and 57 cose reading 288 and 495 cose grading 461 and 403 cose reading 259 and 302 cose reading 317 and 332 cose reading 317 and 332 cose reading 344, 279 and 346 cose reading 344, 279 and 346 cose reading 344 cose reading Kwikpen 4 unch and dinner 10 minutes continuits in the morning. In ed sliding scale Humalog Kwik cheduled insulin before meals 60- no insulin, 151-199 give 1	W3	331		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3		E SURVEY PLETED
		24G435	B. WING			C 1 2/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	1 017	12/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	diabetic with heart of refuse his medication refusing his meals in the report indicated and took his evenindate listed on the refusive of C1's Profollowing: - 11/25/21, at 11:30 11:03 a.m. writer to as 348. C1 informed his brother's house the blue pen. (inconglucose over 400). nurse and was instructured and was instructur	C1 was an insulin dependent conditions and continued to ons with no reason and orepared for him. In addition, C1 had returned at 4:00 a.m. g medications upon return (no eport). gress Notes indicated the a.m. C1 returned to home at ok blood glucose documented at staff he took his insulin at and stated he took 12 units in rect dose only to use if blood Staff documented they called tucted to give scheduled ulin and any other morning 00 p.m. refused his blood sliding scale insulin. C1 g to eat later. .m. C1 came down to check and informed staff he already anyone to get his dinner time is sliding scale insulin. ed at 3:45 a.m. blood glucose his medication and went to	W 33			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24G435	B. WING			C 1 2/2022
NAME OF I	PROVIDER OR SUPPLIER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 380 west minnehaha parkway IINNEAPOLIS, MN 55419	1 01/	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	program supervisor facility with family method will be consay he will be back middle of the night. Take his medication they don't even knot taken while he was C1 was hospitalized and low blood pressoncerned about hit hey are working on since he does not nICF-IID facility. The documenting C1's is several areas some others document in very difficult to track In addition, it is difficult to track In addition, it is difficult in the physician had been high or low. During interview on facility registered nuencourage C1 and RN-A stated she is started her visits aft 12/24/21, and assudiscussing with C1 insulin or following I for a diabetic. RN-A have transcribed [Con 10/8/21, with his	1/11/22, at 11:00 a.m. (PS) stated C1 leaves the nember and will not tell them ning back, sometimes he will at 6:00 p.m. and return in the There are times he does not swith him or when he returns, whow much insulin he has gone. The PS further stated in October for hypoglycemia sure and they are very m. In addition the PS stated infinding him a new placement neet the criteria to be in an e PS further indicated staff are blood glucose readings in in the medical profile tab, the progress notes so it is a his blood glucose readings. Cult to locate where and if the notified if C1's readings are 1/11/22, at 12:08 p.m. the larse (RN)-A stated they try to redirect him to take his insulinated the previous nurse left on med the previous nurse left on med the previous nurse was the risks of not taking his his dietary recommendations A stated, "The staff should 1's] hospital discharge orders blood glucose parameters incian and it appears it was	W 331			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3		E SURVEY PLETED
		24G435	B. WING _			C 1 2/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	1 01/	12/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	During observation 12:26 p.m. C1 states frequently to visit hi he has diabetes. C machine in which tr C1 stated when he phone that alerts hi and has a sliding so insulin he needs to "just takes a little m that seems good wi guide from the doct with C1 on 1/12/22, had not provided hi of not taking his insuling he reinospitalized for low medications were chospitalized for low medications were chospitalization. A Integrated Treatm indicated the follow Medication Manage better on medication improve his health. People 2 staff are reassisting C1 with his Eating Healthier: St for meals and snac program RN. The pataff are responsible to work on his goals make healthier food indicated how data check and documents.	and interview 1/11/22, at and interview 1/11/22, at and he leaves the facility is family member and stated at showed writer his glucose acks his blood glucose levels. I leaves he has an alarm on his im to check his blood sugars cale to tell him how much take and if its a little high he ore maybe 2-3 extra units and atth out using the sliding scale for." An additional interview at 11:28 a.m. he stated staff im with education on the risks ulin according to schedule and not taking it. C1 then stated members is once he was blood sugar and thought his hanged after the	W 33			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		24G435	B. WING		01	C / 12/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419		712/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		IOULD BE	(X5) COMPLETION DATE
W 331	or hyperglycemia (h During interview on and program mana Integrated Treatme completed by the state client's record. have any forms to the programs are being the programs should reviewed at least mupdated as needed programs should hadate of 12/15/21. People Incorporate Management of Me Emergencies policy When to assist client provider: If the client: -is sick and cannon has been vomiting than 6 hours -has blood sugar le	glycemia (low blood glucose) high blood glucose). 1/11/22, at 2:10 p.m. with PS ger (PM). The PS stated C1's nt Plan was supposed to be taff daily and documented in The PS stated they do not rack to make sure the geompleted. The PM stated d be tracked formally and onthly for progress and be. The PM stated the ave been started on the start of Mental Health Services edical Conditions and a undated indicated: Into in contacting a health care control his/her blood sugar or has had diarrhea for more well that stays higher than the set (for example: 300 mg/dl	W 3	331		

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		01556	B. WING			2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PEOPLE	: II		ST MINNEHA OLIS, MN 5	HA PARKWAY 5419		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
5 000	Initial Comments		5 000			
5 000	In accordance with 144.56 and/or Minn 144.653, this correct pursuant to a surver found that the deficit herein are not corrected shall with a schedule of the Minnesota Deposition of the Minnesota Deposition of the Minnesota MN Ruindicated below. We several items, failuritems will be considered of the multi-part ruassessment of a fir violated during the corrected. You may request a that may result from orders provided that the Department wit notice of assessment of a fir violated during the corrected. You may request a that may result from orders provided that the Department wit notice of assessment of a fir violated during the corrected. The following comparison of the following comparison	hether a violation has been compliance with all a rule provided at the tag alle number or MN Statute. Then a rule or statute contains the to comply with any of the lered lack of compliance. It is upon re-inspection with any alle will result in the ne even if the item that was initial inspection was the aring on any assessments in non-compliance with these at a written request is made to thin 15 days of receipt of a cent for non-compliance. The 1/12/22, a complaint conducted. Your facility was obliance with requirements of chapter 4665 requirements for facilities (SLF).	5 000			

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

TITLE (X6) DATE

	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:					
		01556	B. WING		01/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
PEOPLE	: 11		ST MINNEHA OLIS, MN 5	HA PARKWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
5 380	Health services share optimal general lever function, prevent discovered by: This MN Requirement by: Based on observation review, the facility for (C1) followed physician prescribed blook calling the physician to inform client of riscorders and implement training program for Findings include: C1's Client Face Shard Diabetes Mellith (high concentration) C1's Comprehensive (CFA) updated 11/2 to understand and medical health and solve insulin by issues leep, etc. impacts indicated C1 will lead or having medicated C1's Abbott Hospitat 10/08/21, indicated hypoglycemia (low pressure. The discovered in the control of	ent is not met as evidenced on, interview and document ailed to ensure 1 of 1 clients cian prescribed insulin orders od glucose parameters for n. Additionally, the failed failed sk vs benefits of not following ent medication administration of C1. The eet dated 9/1/21, indicated he us Type 2 and hyperlipidemia of lipids or fat in blood). The Functional Assessment of 1021, indicated C1 was unable retain information related to had limited ability to problem uses and understand how food, diabetes. The CFA further are house without telling staff	5 380			

Minnesota Department of Health

STATE FORM 6899 J0V011 If continuation sheet 2 of 7

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			SURVEY LETED	
		01556	B. WING		01/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	1380 WES		STATE, ZIP CODE NHA PARKWAY 5419		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
5 380	with his medication The hospital dischal check his blood gluctontact health care following readings: -Hyperglycemia une 250 milligrams/decimore than 2 times in -Hypoglycemia reactimes in the same dimes in the same dimes in the same dimes in the same dimes in the following from 1 documentation C1's out of range blood gluctory occurred: 10/10/21 blood gluctory 10/14/21 blood gluctory 11/14/21 blood gluctory 11/14/22 blood gluctory 11	regimen. rge orders instructed to cose four times a day and to provider if he had the explained glucose readings of liter (mg/dl) or greater for	5 380			

Minnesota Department of Health

STATE FORM 6899 J0V011 If continuation sheet 3 of 7

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		01556	B. WING			2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PEOPLE	: II		T MINNEHA OLIS, MN 5	HA PARKWAY 5419		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
5 380	12/27/21, indicated diabetic with heart or refuse his medication refusing his meals the report indicated and took his evenind date listed on the research of C1's Profollowing: - 11/25/21, at 11:30 11:03 a.m. writer to as 348. C1 informed his brother's house the blue pen. (inconglucose over 400). nurse and was instrustus 18 units instructus 19/21/21, at 7:30 phis blood glucose at and did not tell insulin. He took his -12/23/21, C1 arrived level 313. He took cook him something -12/25/21, at 12:15 levels were 325 and to bed (order is for Review of all of the indication of staff to benefits of not check the importance of to insulin and prior to	C1 was an insulin dependent conditions and continued to ons with no reason and prepared for him. In addition, C1 had returned at 4:00 a.m. og medications upon return (no eport). gress Notes indicated the a.m. C1 returned to home at ok blood glucose documented ed staff he took his insulin at and stated he took 12 units in rect dose only to use if blood Staff documented they called ructed to give scheduled ulin and any other morning 00 p.m. refused his blood sliding scale insulin. C1 g to eat later. a.m. C1 came down to check and informed staff he already anyone to get his dinner time is sliding scale insulin. ed at 3:45 a.m. blood glucose his medication and went to	5 380			

Minnesota Department of Health

STATE FORM 5899 J0V011 If continuation sheet 4 of 7

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		01556	B. WING			2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
PEOPLE	II		T MINNEHA OLIS, MN 5	HA PARKWAY 5419		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
5 380	During interview on program supervisor facility with family method when he will be corsay he will be back middle of the night. take his medication they don't even know taken while he was C1 was hospitalized and low blood pressoncerned about hit hey are working or since he does not nICF-IID facility. The documenting C1's is several areas some others document in very difficult to track In addition, it is diffiphysician had been high or low. During interview on facility registered numericourage C1 and RN-A stated she is started her visits aff 12/24/21, and assudiscussing with C1 insulin or following for a diabetic. RN-A	1/11/22, at 11:00 a.m. (PS) stated C1 leaves the nember and will not tell them ning back, sometimes he will at 6:00 p.m. and return in the There are times he does not is with him or when he returns, whow much insulin he has gone. The PS further stated do in October for hypoglycemia sure and they are very m. In addition the PS stated of finding him a new placement neet the criteria to be in an in the PS further indicated staff are plood glucose readings in the medical profile tab, the progress notes so it is at his blood glucose readings. Cult to locate where and if the inotified if C1's readings are 1/11/22, at 12:08 p.m. the curse (RN)-A stated they try to redirect him to take his insulinater the previous nurse left on med the previous nurse was the risks of not taking his his dietary recommendations A stated, "The staff should cit's] hospital discharge orders	5 380			
	and calling his phys never done." During observation	and interview 1/11/22, at the leaves the facility				

Minnesota Department of Health

STATE FORM 5899 J0V011 If continuation sheet 5 of 7

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		01556	B. WING		1	, 2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PEOPLE II			T MINNEHA OLIS, MN 5	.HA PARKWAY 5419		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
5 380	frequently to visit his he has diabetes. Of machine in which the C1 stated when he phone that alerts his and has a sliding so insulin he needs to "just takes a little methat seems good with c1 on 1/12/22, had not provided his of not taking his insuling the side effects of medications were of the only thing he rehospitalized for low medications were of hospitalization. A Integrated Treatmedicated the follow Medication Manage better on medication improve his health. People 2 staff are massisting C1 with his Eating Healthier: Staff are responsible to work on his goals make healthier food indicated how data check and docume four times a day. A would be less hypo	s family member and stated of showed writer his glucose racks his blood glucose levels. Ieaves he has an alarm on his m to check his blood sugars cale to tell him how much take and if its a little high he agree maybe 2-3 extra units and ith out using the sliding scale for." An additional interview at 11:28 a.m. he stated staff m with education on the risks culin according to schedule and not taking it. C1 then stated members is once he was a blood sugar and thought his changed after the	5 380			

Minnesota Department of Health

STATE FORM 5899 J0V011 If continuation sheet 6 of 7

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY	AND PLAN OF CORRECTION		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY			
1380 WEST MINNEHAHA PARKWAY			
13XII WEST MINNEHAHA PARKWAY	NAME OF PROVIDER OR SUF		
PEOPLE II MINNEAPOLIS, MN 55419	PEOPLE II		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X COMPRESS) PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PLAN OF CORRECTION (X COMPRESS) PROVIDER'S PROVIDE	PREFIX (EACH DEF		
5 380 Continued From page 6 During interview on 1/11/22, at 2:10 p.m. with PS and program manager (PM). The PS stated C1's Integrated Treatment Plan was supposed to be completed by the staff daily and documented in the client's record. The PS stated they do not have any forms to track to make sure the programs are being completed. The PM stated the programs should be tracked formally and reviewed at least monthly for progress and be updated as needed. The PM stated the programs should have been started on the start date of 12/15/21. People Incorporated Mental Health Services Management of Medical Conditions and Emergencies policy undated indicated: When to assist clients in contacting a health care provider: If the client: -is sick and cannon control his/her blood sugar -has been vomiting or has had diarrhea for more than 6 hours -has been vomiting or has had diarrhea for more than 6 hours -has been vomiting or has had diarrhea for more than 6 hours -has been vomiting or has had provided for two or more readings). TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	During interviand program Integrated Trucompleted by the client's rehave any form programs are the programs reviewed at leupdated as no programs should be a supposed by the client of 12/15. People Incorport Management Emergencies When to assist provider: If the client: -is sick and contain the chast been voor than 6 hours of two or motions.		

Minnesota Department of Health

STATE FORM 56899 J0V011 If continuation sheet 7 of 7



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

January 26, 2022

Administrator People Ii 1380 West Minnehaha Parkway Minneapolis, MN 55419

Re: Event ID: JOVO11

Dear Administrator:

The above facility survey was completed on January 12, 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, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Kim Tron

Saint Paul, Minnesota 55164-0970

Phone: 651-201-3831

Email: kim.tyson@state.mn.us

PRINTED: 01/26/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		E SURVEY PLETED
						(C
		24G435	B. WING			01/	12/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PEOPLE	II				380 WEST MINNEHAHA PARKWAY IINNEAPOLIS, MN 55419		
	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		IV	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	On 1/11/22 throug survey was conduc. The facility was fou with the requiremer for Intermediate Ca with Intellectual Dis. The following comp substantiated: HG4 deficiencies issued. The Condition of Pa Services 483.460 w. HEALTH CARE SE CFR(s): 483.460	and approved 2/16/22 h 1/12/22, an abbreviated ted to investigate a complaint. nd NOT to be in compliance at sof 42CFR 483 Subpart I, are Facilities for Individuals abilities (ICF/IID). Idaint below was found to be 35024C (MN79743) with at W331. Participation: Health Care as found not met. RVICES	w		C1 discharged from the program of 1/26/2022 due to a determination to the program was not an appropriate Therefore, we are unable to take a to correct the specific deficiency. However, we will take the following actions to ensure that similar issue not occur in the future: 1. Staff were retrained on the transcription procedures outlined in Medication Policy and Procedures Manual on 2/10/2022 by the Nursin Manager. (Program Supervisor) 2. Conduct documentation review current clients and correct if any transcribed orders are missing information. (Program Supervisor) 3. Conduct monthly audits of transcriptions of physician orders fronths. (Program Manager)	that te fit. action es do n our ng	2/10/22
	Based on interview Condition of Particip Health Care Service failed to provide add 1 clients (C1) who will multiple occasions extended periods of physician prescribe Findings include: See W331: The fact physician's orders with C1). Additionally, the condition of the condition	ility failed to ensure were followed for 1 of 1 clients			The Program Manager will be responsible for overseeing the completion of this plan.		
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		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.

Compliance Coordinator

2/16/2022

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		24G435	B. WING				C 1 2/2022	
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	12/2022	
PEOPLE	II				380 WEST MINNEHAHA PARKWAY			
040.15	CUMMA DV CTA	TEMENT OF DEFICIENCIES	ID	IV	MINNEAPOLIS, MN 55419	A.I	045)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE	
W 318	Continued From pa	ge 1	w a	318				
W 331	orders and failed to administration prog NURSING SERVIC CFR(s): 483.460(c)	ES	W 3	331				
	services in accorda This STANDARD is Based on observat review, the facility fa (C1) followed physic and prescribed bloc calling the physiciar to inform client of ris orders and implementationing program for	ovide clients with nursing nce with their needs. It is not met as evidenced by: sion, interview and document ailed to ensure 1 of 1 clients cian prescribed insulin orders and glucose parameters for the n. Additionally, the failed failed sk vs benefits of not following the medication administration or C1.						
	Findings include:							
	had Diabetes Mellit	neet dated 9/1/21, indicated he us Type 2 and hyperlipidemia of lipids or fat in blood).						
	(CFA) updated 11/2 to understand and r medical health and solve insulin by issusleep, etc. impacts	ve Functional Assessment (021, indicated C1 was unable retain information related to had limited ability to problem use and understand how food, diabetes. The CFA further ave house without telling staffons.						
	10/08/21, indicated hypoglycemia (low loressure. The disc	al discharge orders dated he was hospitalized for blood sugar) and low blood harge orders sent to Peoples dicated C1 to be compliant regimen.						

	FOF DEFICIENCIES OF CORRECTION				OATE SURVEY COMPLETED	
		24G435	B. WING		01	C I /12/2022
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419			II I LI LULL
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 331	check his blood glucontact health care following readings: -Hyperglycemia und 250 milligrams/decimore than 2 times in -Hypoglycemia readimes in the same of week. Review of C1's blood the following from 1 documentation C1's out of range blood goccurred: 10/10/21 blood glucont/1/21 blood glucont/1/21 blood glucont/1/21 blood glucont/1/21 blood glucont/1/22 blood glucont/1	rge orders instructed to cose four times a day and to provider if he had the explained glucose readings of liter (mg/dl) or greater for	W 3	31		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		24G435	B. WING		01	C /12/2022	
NAME OF I	PROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CO 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 331	diabetic with heart refuse his medicatirefusing his meals the report indicated and took his evenir date listed on the refusion of C1's Profollowing: - 11/25/21, at 11:30 11:03 a.m. writer to as 348. C1 informs his brother's house the blue pen. (incorglucose over 400). nurse and was inst Lantus 18 units ins medications. -11/28/21, C1 at 6:0 glucose check and stated he was going-11/29/21, at 7:30 phis blood glucose at and did not tell insulin. He took his -12/23/21, C1 arrivelevel 313. He took cook him somethin -12/25/21, at 12:15 levels were 325 and to bed (order is for Review of all of the indication of staff to benefits of not check the importance of to insulin and prior to	C1 was an insulin dependent conditions and continued to ons with no reason and prepared for him. In addition, I C1 had returned at 4:00 a.m. or medications upon return (no eport). gress Notes indicated the a.m. C1 returned to home at ok blood glucose documented ed staff he took his insulin at and stated he took 12 units in trect dose only to use if blood Staff documented they called ructed to give scheduled ulin and any other morning to p.m. refused his blood sliding scale insulin. C1 g to eat later. o.m. C1 came down to check and informed staff he already anyone to get his dinner time is sliding scale insulin. ed at 3:45 a.m. blood glucose his medication and went to	W 3	31			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24G435	B. WING		01/1	C 1 2/2022
	PEOPLE II			TREET ADDRESS, CITY, STATE, ZIP CODE 380 west minnehaha parkway IINNEAPOLIS, MN 55419	1 017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	program supervisor facility with family method will be consay he will be back middle of the night. Take his medication they don't even knot taken while he was C1 was hospitalized and low blood pressoncerned about hit hey are working on since he does not nICF-IID facility. The documenting C1's is several areas some others document in very difficult to track In addition, it is difficult to track In addition, it is difficult in the physician had been high or low. During interview on facility registered nuencourage C1 and RN-A stated she is started her visits aft 12/24/21, and assudiscussing with C1 insulin or following I for a diabetic. RN-A have transcribed [Con 10/8/21, with his	1/11/22, at 11:00 a.m. (PS) stated C1 leaves the nember and will not tell them ning back, sometimes he will at 6:00 p.m. and return in the There are times he does not swith him or when he returns, whow much insulin he has gone. The PS further stated in October for hypoglycemia sure and they are very m. In addition the PS stated infinding him a new placement neet the criteria to be in an e PS further indicated staff are blood glucose readings in in the medical profile tab, the progress notes so it is a his blood glucose readings. Cult to locate where and if the notified if C1's readings are 1/11/22, at 12:08 p.m. the larse (RN)-A stated they try to redirect him to take his insulinated the previous nurse left on med the previous nurse left on med the previous nurse was the risks of not taking his his dietary recommendations A stated, "The staff should 1's] hospital discharge orders blood glucose parameters incian and it appears it was	W 331			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3	(X3) DATE S COMPL	
		24G435	B. WING _			C 1 2/2022
	PEOPLE II (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	1 01/	12/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	During observation 12:26 p.m. C1 states frequently to visit hi he has diabetes. C machine in which tr C1 stated when he phone that alerts hi and has a sliding so insulin he needs to "just takes a little m that seems good wi guide from the doct with C1 on 1/12/22, had not provided hi of not taking his insuling he reinospitalized for low medications were chospitalized for low medications were chospitalization. A Integrated Treatm indicated the follow Medication Manage better on medication improve his health. People 2 staff are reassisting C1 with his Eating Healthier: St for meals and snac program RN. The pataff are responsible to work on his goals make healthier food indicated how data check and documents.	and interview 1/11/22, at and interview 1/11/22, at and he leaves the facility is family member and stated at showed writer his glucose acks his blood glucose levels. I leaves he has an alarm on his im to check his blood sugars cale to tell him how much take and if its a little high he ore maybe 2-3 extra units and atth out using the sliding scale for." An additional interview at 11:28 a.m. he stated staff im with education on the risks ulin according to schedule and not taking it. C1 then stated members is once he was blood sugar and thought his hanged after the	W 33			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SUR COMPLETI	
		24G435	B. WING			0
NAME OF PROVIDER OR SUPPLIER PEOPLE II			9	TREET ADDRESS, CITY, STATE, ZIP CODE 380 WEST MINNEHAHA PARKWAY	01/°	12/2022
			N	MINNEAPOLIS, MN 55419		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	or hyperglycemia (h During interview on and program mana. Integrated Treatme completed by the st the client's record. have any forms to t programs are being the programs shoul reviewed at least m updated as needed programs should ha date of 12/15/21. People Incorporate Management of Me Emergencies policy When to assist clief provider: If the client: -is sick and cannon -has been vomiting than 6 hours -has blood sugar le	glycemia (low blood glucose) high blood glucose). 1/11/22, at 2:10 p.m. with PS ger (PM). The PS stated C1's not Plan was supposed to be aff daily and documented in The PS stated they do not rack to make sure the accompleted. The PM stated do be tracked formally and onthly for progress and be are been started on the start. If Mental Health Services dical Conditions and a undated indicated: Into in contacting a health care control his/her blood sugar or has had diarrhea for more well that stays higher than the set (for example: 300 mg/dl	W 331			