Electronically Delivered Via Email on May 19, 2022

Adminstrator
People II
1380 West Minnehaha Parkway
Minneapolis, MN 55419

RE: Event ID: XJ1012

Dear Administator:

On May 2, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a survey, completed on May 14, 2022. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our PCR, we have determined that your facility has not corrected all of the deficiencies issued pursuant to our survey, completed on May 2, 2022.

The following Condition of Participation (COP) were found corrected:

W195 42 CFR 483.440 Active Treatment Services
W122 42 CFR 483.440 Client Protections

The following deficency was not corrected at the time of the revisit: W237-Individual Program Plan

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:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction

is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

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

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

March 29, 2022

Administrator
People Ii
1380 West Minnehaha Parkway
Minneapolis, MN 55419

RE: Event ID: XJ1011

Dear Administrator:

On March 14, 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 14, 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):

W195 42 CFR § 483.440 Active Treatment Services
W122 42 CFR § 483.440 Client Protections

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 May 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

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
	24G435	A. BUILDING _____ B. WING _____	C 03/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEOPLE II	**1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419**

(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 3/8/22 through 3/14/22, 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. The following complaints were found to be SUBSTANTIATED: HG435025C (MN81505 and MN81502) Immediate Jeopardy was cited at W127. The Condition of Client Protection 42 CFR 483.420 was found not to be met. See W127. The IJ began on 2/20/22, when the facility failed to ensure safety of C1 who left the facility in the middle of the night, was sexually assaulted, videotaped and placed on social medial. The program supervisor was informed of the IJ on 3/11/22, at 5:11 p.m. The immediate jeopardy was removed on 3/14/22, at 4:06 p.m. when the facility's approved removal plan was verified onsite by the state agency. The Condition of Participation: Active Treatment Services 42 CFR 483.440 was found not to be met. See W198, W206 and W252. In addition, the finding of W159 and W455 were cited. 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 122	CLIENT PROTECTIONS	W 122		

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 122	Continued From page 1 CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection was not met. The facility failed to protect 1 of 1 clients (C1) from sexual abuse who was sexually assaulted. Findings include: See W127: the facility failed to protect a client from sexual abuse for 1 of 1 client (C1) review for abuse. The facility allowed C1 to leave the facility in the middle of the night to meet her boyfriend. C1 was sexually assaulted, videotaped on snap chat, and left stranded at a park. This resulted in an immediate jeopardy (IJ).	W 122		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, interview and document review the facility failed to protect a client from sexual abuse for 1 of 1 client (C1) review for abuse. The facility allowed C1 to leave the facility in the middle of the night to meet her boyfriend. C1 was sexually assaulted, videotaped on snap chat, and left stranded at a park. This resulted in an immediate jeopardy (IJ).	W 127		

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W 127	Continued From page 2 The IJ began on 2/20/22, when the facility failed to ensure safety of C1 who left the facility in the middle of the night and was sexually assaulted which was videotaped and placed on social media. The program supervisor was informed of the IJ on 3/11/22, at 5:11 p.m. The immediate jeopardy was removed on 3/14/22, at 4:06 p.m. when the facility's approved removal plan was verified onsite by the state agency. Findings include: C1's Client Face Sheet undated indicated she had diagnosis of mild to moderate intellectual disability, bipolar disorder, and fetal alcohol syndrome. C1's Crisis Stabilization Plan (CSP) dated 12/16/21, indicated she goes on dating sites and is quick to seek out men. The CSP indicated C1's plan to make safer decisions was to block phone numbers, delete sites, talk with staff, and talk with mom or grandmother. C1's Individual Abuse Prevention Plan (IAPP) dated 12/19/21, indicated she has a history of sexual abuse, and would not report abuse in a timely manner or to the appropriate authorities. A Facility Reported Incident (FRI) dated 2/22/22, indicated on 2/20/22, C1 asked for her medications to be packed for three days and told staff she was going to see her boyfriend at 3:00 a.m. and if wanted they could call her mother since she knows him. C1 never went to the boyfriend's apartment instead C1 and her boyfriend walked to a park where he asked for oral sex and C1 complied. C1 indicated she	W 127		

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W 127	Continued From page 3	W 127		

refused to have intercourse with her boyfriend, and he left her alone in the park. C1 did not have enough money for a transportation to get back to the facility, was crying, and called her mother for a ride. It was reported C1's boyfriend recorded the oral sex and put the recording on a social media platform, Snap Chat.

During an interview on 3/08/22, at 2:00 p.m. program supervisor (PS) stated C1 is her own guardian and makes her own decisions. The facility is concerned about her making bad decisions but does not know what to do but try to discourage her from making those bad decisions. The PS stated the park police were called and they came out and filed a report. The PS stated the staff should have called the family or the support person but doubts they would have answered at 3:00 a.m. In addition, the program supervisor stated per her CSP, C1 is supposed to leave with a pull string alarm to use if she was in a bad situation. C1 could pull string and a loud alarm would go off; however, it was not sent with her that night. At a later interview, PS stated following the incident there was no investigation or re-training for staff to ensure the CSP was followed and C1 was more protected in the future.

During an interview on 3/08/22, at 6:28 p.m. with C1 ' s family member who stated C1 does make her own decisions, but she is not making good ones. C1's family member stated they wished on the night of 2/20/22, the staff would have called her or her support person so they could have attempted to stop her from leaving the facility. The family member felt if they talked to her the incident probably never would have happened and stated, "nothing good happens after dark".

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W 127	Continued From page 4 During an interview on 3/9/22, at 9:30 a.m. C1 stated on the night of 2/20/22, she called an Uber (taxi service) and went to meet her boyfriend and walked to a park where she performed oral sex while he tapped it. C1 then stated she does not want to talk about this anymore and walked away. During an interview on 3/10/22, at 1:34 p.m. mental health support specialist (MHSS)-A stated she was working the night of 2/20/22 and was informed by the evening shift her medications were packed for 3 days and she was going to her boyfriends. MHSS-A stated she thought it was ok to just let her leave even though it was 3:00 a.m. since she was her own guardian and decision maker. MHSS-A stated she never did call C1 ' s mother because she was never instructed to do so and was not aware that C1 was supposed to leave with a pull string alarm. MHSS-A stated she has left during the night shift while she had been working three other times. During an interview on 3/10/22, at 2:00 p.m. MHSS-B stated there was no education provided to prevent a reoccurrence related to C1 of C1's recent leaving on 2/20/22. In addition, MHSS-B stated he attended C1's TACT (Transition Age Community Treatment) team which was a program that provides community-based mental health services to adolescents and young adults who are struggling with functioning at home, in school, or in the community due to a serious mental health diagnosis. The TACT team also had concerns with C1 leaving and thinking this was unsafe. MHSS-B stated the TACT team meets with C1 weekly and was unsure what the TACT teams plan was to address the issue of C1 leaving.	W 127		

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W 127	Continued From page 5 The immediate jeopardy that began on 2/20/22, was removed on 3/14/22, at 4:06 p.m. when C1 was re-assessed for safety needs and updates to C1's Individual Abuse Prevention Plan and Crisis Safety Plan, staff training of the updates and verification of the training.	W 127		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the qualified intellectual disabilities professional (QIDP) had consistent oversight of each client's needs and individual program plans so that each client received the care and services needed to maintain their highest level of functioning for 5 of 5 clients (C1, C2, C3, C4 and C5) programs that were reviewed. Findings include: The QIDP failed to ensure the client's programs were individualized, monitored, and evaluated on an ongoing basis as follows: During an interview on 3/10/22, at 9:48 a.m. the program manager (PM) stated she and the program supervisor (PS) took over Peoples II (ICF) in October 2020 and there was no programing set up for the clients and they started working on setting up programing in January 2022 for the clients. The PM stated they were not collecting data and there was no implementation of goals, but they plan to start them going	W 159		

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W 159	Continued From page 6 forward. During an interview on 3/14/22, at 11:44 a.m. the vice president of operations stated the facility was completing the comprehensive functional assessments as required and there were goals for the clients. The vice president of operations stated it looks like we were not using the data forms like we should have been according to the program plans that were written. A policy was requested on role of QIDP but was not provided.	W 159		
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet the Condition of Participation of Active Treatment (42 CFR 483.440). Findings include: See W198: Thefacility failed to ensure clients living at the facility were in need of active treatment for 1 of 3 clients (C2) who were not assessed to require training and not currently receiving active treatment services. See W206. The facility failed to have individual program goals identified and implemented based on the clients needs 1 of 3 clients reviewed (C1)	W 195		

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W 195	Continued From page 7 for active treatment. See W252. The facility failed to ensure that staff implemented programs and collected data according to the frequency identified in the Integrated Treatment Plan (ITP) so client programs could be monitored and revised based on client progress or regression for 1 of 3 clients (C3) reviewed for active treatment.	W 195		
W 198	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(1) Clients who are admitted by the facility must be in need of and receiving active treatment services. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to ensure clients living at the facility were in need of active treatment for 1 of 3 clients (C2) who were not assessed to require training and not currently receiving active treatment services. Findings include: C2's Client Face Sheet undated indicated C2 had mild intellectual disability,generalized anxiety disorder, major depression and panic disorder. C2's Comprehensive Functional Assessment (CFA) dated 11/2021, indicated C2 had no dietary needs, no mobility needs, has difficulty expressing emotions appropriately and engages in staff support in emotion regulation. The CFA further indicated under Skills Assessment she was independent in all areas of self care, home living skills, cooking skills, and with money	W 198		

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W 198	Continued From page 8 management C2 has the understanding of the value of money is limited. The CFA indicated she needs no help in community skills, and with behavioral does have difficulty with decision making and staff does provide support. During interview on 3/14/22, at 10:00 a.m. program supervisor (PS) stated C2 has no active programing and never has since she had admitted to the facility approximately a year ago. The PS stated she frequently is staying at her boyfriend's place and is not at the home very often and they really don't do much for her. The PS stated the TACT (Transition Age Community Treatment) team which was a program that provides community-based mental health services to adolescents and young adults who are struggling with functioning at home, in school, or in the community due to a serious mental health diagnosis has been working with her and has goals they might work on, but the home has nothing to do with them. The PS stated they are now starting to track her days she is gone because they believe she has almost used her allowed time per year to be overnight out of the home which was approximately 75 days a year. During an interview 3/14/22, at 11:20 a.m. the PS stated although they are not working on any formal goal's for C2 to transition into the community C2 could be working on the following goals of money management, community activities, focus on self and not others. Review of C2's CFA did not identify evidence of areas C2 would have goals/programming developed with money management and community activities.	W 198		

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W 198	Continued From page 9 During an interview on 3/14/22, at 1:30 p.m. the PS stated the only goal they have for C2 was to track C2's appointments, apply for a job but they are not doing any formal data collection and are not racking her success in these goals to see if she has had any improvement. During an interview 3/14/22, at 3:00 p.m. program manager (PM) stated they are aware the programs need to be updated and to show if they are working and if they need to revise or update. In addition the PM stated C2 was admitted from one of there crisis units of People Inc. and C2 was not assessed correctly from the county to see if C2 was appropriate for placement at the home. The PM stated they are attempting to have C2 assessed and are unsure if she is appropriate to be placed at the facility. Facility Policy People II Active Treatment revised 10/16, indicated "It is the policy of People II to provide each individual with continuous active treatment according to federal and state regulations. Active treatment includes aggressive, consistent implementation of a program to specialized and general education, behavioral support, health, and related services. It enables the individuals to acquire and maintain behaviors and skills necessary to function at their maximum level of independence and self-determination."	W 198		
W 206	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to: (i) Identifying the client's needs, as described by	W 206		

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(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 206	Continued From page 10 the comprehensive functional assessments required in paragraph (c)(3) of this section; and (ii) Designing programs that meet the client's needs. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to have individual program goals identified and implemented based on the clients needs 1 of 3 clients reviewed (C1) for active treatment. C1's Client Face Sheet undated indicated C1 had diagnosis of mild to moderate intellectual disability, bipolar disorder, and fetal alcohol syndrome. C1's Comprehensive Functional Assessment (CFA) dated 11/20/21, indicated she lacks motivation, memory and learning challenges. The CFA further indicated C1 is independent in self care, needs self prompts with home living skills, needs assist with money management, does not understand appropriate use of check card and had impulsive buying. C1's Integrated Treatment Plan (ITP) indicated C1 was open to several programs at People Incorporated, and currently lives at People II. The ITP further indicated she was also served by TACT (Transition Age Community Treatment) team which was a program that provides community-based mental health services to adolescents and young adults who are struggling with functioning at home, in school, or in the community due to a serious mental health diagnosis) and case management. The ITP indicated all programs currently share the same	W 206		

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	24G435	A. BUILDING _____ B. WING _____	C 03/14/2022

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W 206	Continued From page 11 treatment plan. Review of C1's ITP indicated the following programs: Employment: C1 struggles to have more independence, safely in the community and employment was identified as a way to explore her independence. Goal- TACT providers will meet with C1 weekly to discuss the barrier and maintaining employment Intervention: TACT will work to identify barrier, coach her on suitable skills, support in looking for employment that she can manage, and finally role play conflicts that may arise. Independent Living Skills: C1 would like to learn and practice independent living skills of budgeting, meal planning, healthy eating and self-care. Goal- C1 would like to learn and practice independent living skills of budgeting, meal planning, healthy eating and self care. Description- C1 will meet with staff to learn and practice skills of budgeting, making grocery lists, meal planning and learning and improving skills in the kitchen. Social Function: C1 trusts people too quickly and has gotten in trouble	W 206		

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W 206	Continued From page 12 Goal- C1 wants to learn to be more social with people and make more friends. Intervention: Meet with TACT workers to develop safe skills for making new friendships. Case management will meet with C1 monthly to review progress towards goal and discuss topics as needed. Review of C1's records lacked evidence above stated goals were implemented, documented or monitored for changes based on success or regression. During interview on 3/14/22, at 2:00 p.m. program supervisor (PS) stated Peoples II does not have programs written for C1 and they are not documenting any data towards meeting her goals except a progress note and this is not being reviewed. The PS stated they will be starting this moving forward. During interview on 3/14/22, at 2:10 p.m. vice president of operations (VPO) stated they will be meeting with her TACT team on Wednesday and they are working on making measurable goals for C1. The VPO stated the goals are not written with required frequencies and the only data they would have if the programs were being run would be in a progress note from the staff. Facility Policy People II Active Treatment revised 10/16, indicated "It is the policy of People II to provide each individual with continuous active treatment according to federal and state regulations. Active treatment includes aggressive, consistent implementation of a program to specialized and general education, behavioral support, health, and related services. It enables	W 206		

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W 206	Continued From page 13 the individuals to acquire and maintain behaviors and skills necessary to function at their maximum level of independence and self-determination."	W 206		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure that staff implemented programs and collected data according to the frequency identified in the Integrated Treatment Plan (ITP) so client programs could be monitored and revised based on client progress or regression for 1 of 3 clients (C3) reviewed for active treatment. Findings include: C3's Comprehensive Functional Assessment (CFA) dated 11/20/21, indicated C3 had Asperger's (significant difficulties in social interaction and nonverbal communication) , bipolar disorder and anxiety. The CFA further indicated C3 does not like to brush his teeth and can complete home living skills but may refuse. Review of C3's ITP indicated the following: Goal #1 I would like healthy teeth and gums so that I don't get cavities and have bad breath.	W 252		

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W 252	Continued From page 14 Objective: C3 will brush his teeth twice each day. Baseline- This outcome will be consisted achieved when C2 is able to brush his teeth twice daily for an average success rate of 75% each month for 6 months. Staff were to use a tracking sheet using the following codes 0- declined, 1- completed outcome, 2- completed outcome with verbal assistance. 3- completed outcome with physical assistance, NA- outcome not completed. During interview 3/14/22, at 2:30 p.m. mental health support specialist (MHSS)-B stated they document once daily on electronic medical record if he brushed his teeth and are not using the codes. The MHSS-B stated he was not aware they were supposed to be documenting twice daily. The MHSS-B stated C3 almost always refuses. Goal #2 I would like to get better at keeping my clothes clean and put away. Objective: C3 will wash all of his laundry including bedding weekly. Baseline- This goal will be considered achieved when C3 washes and dries his clothes at least 75% of the Fridays each month for 3 consecutive months. Staff were to fill in that day on C3's goal tracking sheet using the following codes 0- declined X-	W 252		

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W 252	Continued From page 15 completed. During interview 3/14/22, at 2:35 p.m. MHSS-C stated C3 washes his clothes about once every other week and she documents this in a progress note and there is no data tracking sheet. During interview 3/14/22, at 3:00 p.m. PS stated C3 does not have a data tracking sheet and they are not tracking his progress towards this goal. People II Active Treatment Policy revised 10/16, indicated they use a structured format to include functional goals and objectives, which are specific, time-limited, observable and measurable.	W 252		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure employees wore appropriate personal protective equipment (PPE) to include eye protection in accordance with the Center of Disease Control (CDC) guidance. This had the potential to affect all five clients in the facility. Findings include: During an observation 3/08/22, at 2:00 p.m. the program supervisor (PS) and the float registered nurse (RN) were observed in the home with a surgical mask and no PPE eye protection on. In	W 455		

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W 455	Continued From page 16 addition, mental health support specialist (MHSS)-B was observed to be wearing a black cloth mask and no PPE eye protection on. MHSS-B was subsequently observed to be assisting the clients with snacks and talking with them thorough the home. During an observation and interview 3/09/22, at 9:33 a.m. the PS was observed to be wearing a surgical mask and no eye PPE on. In addition, MHSS-B was observed to be wearing a black cloth facial mask and no eye PPE. During interview, the PS stated they have been laxed on wearing the eye PPE and really have not been wearing them for months and informed MHSS-B to put on a surgical mask. During an interview 3/09/22 at 9:45 a.m. the MHSS-B stated during his orientation in January 2022, he was never informed he needed to wear eye PPE and had not been wearing them since he had started. Additionally, MHSS-B stated he has not noticed any of the staff wearing eye PPE. People Incorporated's COVID-19 Plan for Adult Foster Care/Community Residential Services-People II undated indicated People Incorporated will provide staff with surgical grade facial masks and face shields or eye goggles for protection.	W 455		

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	01556	A. BUILDING: _____ B. WING _____	C 03/14/2022

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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 3/8/22 through 3/14/22, 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 complaint was found to be SUBSTANTIATED with no licensing orders issued: HG435025C (MN81505 and MN81502).	5 000		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 29, 2022

Electronically Delivered

Administrator
People II
1380 West Minnehaha Parkway
Minneapolis, MN 55419

Re: Event ID: XJ1011

Dear Administrator:

The above facility survey was completed on March 14, 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

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{W 000}	INITIAL COMMENTS Susie Haben On 5/2/22, an onsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited 3/14/22. The facility was found to be not in compliance with the requirements of 42 CFR 483. Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID.) 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}	received 5/25/22 approved 5/25/22 POC 6/9/22	
W 237	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(iv) Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to identify the type and frequency of data collection to assess progress toward the desired goals for 3 of 3 clients (C1, C2 and C3) whose goals were reviewed for active treatment. Findings include: C1's Comprehensive Functional Assessment (CFA) dated 11/20/21, indicated C1 had major depression disorder and binge eating disorder. The CFA further indicated staff administered her medications, had mood disorder with learning challenges, vulnerable with money doesn't understand value of money with impulsive	W 237	1. The treatment plan format has been updated to include data and data collection requirements. 2. Client's treatment plan and goals were updated to include specific data and frequency of data collection. 3. All clients' treatment plans and goals will be reviewed and updated if necessary 4. Staff will be retrained on all client's treatment plans on June 9th 5. Treatment plans will be reviewed every 90 days by Program Supervisor in order to ensure compliance going forward. 6. The Program Supervisor and Program Manager will conduct monthly audits on all treatment plans/goals sessions/data tracking for 3 months. The Program Manager will ensure the completion of this plan.	6/9/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Cil Chute	Compliance Coordinator	5/25/2022

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 237	Continued From page 1 spending, verbal aggression and sexual behavior seeking unknown safe partners. In addition the CFA indicated staff support medical health. Review of C1's Program Goals dated April 2022 indicated the following goals: Area: Mental Health Coping Skills Goal: C1 will select from coping skills (3 identified options) when feeling angry. Staff will prompt. Staff were provided a calendar where the would initial daily under AM or PM if the task occurred. Area:Self Care Goal: C1 will use my CPAP machine at least three full nights per week. Staff were provided a calendar where the would initial daily under AM or PM if the task occurred. Area:Safety Plan Goal: C1 will meet with staff and make a safety plan when C1 was leaving the program. Area: Financial Goal: C1 will meet with staff weekly to review her budget. C1's goal did not indicate what day of the week the goal was to be ran and if C1 needed prompts, verbal cues or could do them independently. The goals also did not identify how they would be tracked and how progress would be determined. C2's CFA dated 11/20/21, indicated C2 had bipolar disorder and anxiety. The CFA further indicated C2 does not like to brush his teeth and required daily reminders, can do room care but "just won't due it", and receives money from rep-payee after C2 completes his chores.	W 237		

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W 237	Continued From page 2 Review of C2's Program Goals dated April 2022 indicated the following goals: Area:Self Care/Independent Living Capacity Goal: C2 will clean room weekly (clothes picked up, bed made.) Area: Self Care/Independent Living Goal: Staff will prompt weekly to wash clothes Area:Finance Goal: C2 will meet with staff weekly to review budget. Area:Self Care/Independent Living Goal: Will brush his teeth two times a week C2's goal did not indicate what day of the week the goal was to be ran and if C2 needed prompts, verbal cues or could do them independently. The goals also did not identify how they would be tracked and how progress would be determined. Review of C3's record indicated C3 did not have a completed CFA. Review of C3's Program Goals dated April 2022 indicated the following goals: Area: Financial Goal: C3 will meet with staff on a weekly basis to review budgets. Area: Self Care/Independent Living Capacity Goal: Staff will prompt C3 to bathe every other day Area: Self Care/Independent Living Capacity	W 237		

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W 237	Continued From page 3 Goal: Staff will remind C3 to weekly do his laundry Area: Self Care/Independent Living Capacity Goal: I will meet with staff weekly to practice my cooking. C3's goals did not indicate what day of the week the goals were to be ran and if C3 needed prompts, verbal cues or could do them independently. The goals also did not identify how they ' ll would be tracked and how progress would be determined. In addition C3 lacked to have a CFA to find needs or goals C3 should be working on. During interview on 5/2/22, at 11:55 a.m. program manager (PM) stated the goals were set up according to the client needs and after review of the regulation confirmed an understanding the goals written lacked to have ways to track progression and should have more information in the goals such as when they should be completed, percentages to achieve so they could track from month to month and include a rational. The PM stated she will be working on changing the goals immediately. People II Active Treatment Policy revised 10/16, indicated they use a structured format to include functional goals and objectives, which are specific, time-limited, observable and measurable.	W 237		

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W 000	INITIAL COMMENTS On 3/8/22 through 3/14/22, 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. The following complaints were found to be SUBSTANTIATED: HG435025C (MN81505 and MN81502) Immediate Jeopardy was cited at W127. The Condition of Client Protection 42 CFR 483.420 was found not to be met. See W127. The IJ began on 2/20/22, when the facility failed to ensure safety of C1 who left the facility in the middle of the night, was sexually assaulted, videotaped and placed on social medial. The program supervisor was informed of the IJ on 3/11/22, at 5:11 p.m. The immediate jeopardy was removed on 3/14/22, at 4:06 p.m. when the facility's approved removal plan was verified onsite by the state agency. The Condition of Participation: Active Treatment Services 42 CFR 483.440 was found not to be met. See W198, W206 and W252. In addition, the finding of W159 and W455 were cited. 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	Susie Haben POC 4/29/22 reviewed and approved 4/21/22	
W 122	CLIENT PROTECTIONS	W 122		

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

Trisha Stachowski | Compliance Coordinator | 4/6/2022

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 122	Continued From page 1 CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.420 Client Protection was not met. The facility failed to protect 1 of 1 clients (C1) from sexual abuse who was sexually assaulted. Findings include: See W127: the facility failed to protect a client from sexual abuse for 1 of 1 client (C1) review for abuse. The facility allowed C1 to leave the facility in the middle of the night to meet her boyfriend. C1 was sexually assaulted, videotaped on snap chat, and left stranded at a park. This resulted in an immediate jeopardy (IJ).	W 122	Each resident's IAPP will be reviewed and the necessary changes will be made to ensure that all vulnerabilities are identified and a plan is in place. Staff will be trained on each updated IAPP at the staff meeting. Program Leadership will ensure that employee training is complete, and that completion is properly documented. Each IAPP will be reviewed and updated every 6 months, with the QIDAP approving the plan. The Program Manager will provide oversight and monthly auditing for the next quarter, then move to a semi-annual auditing process. **Owner:** Program Manager	4/15/22
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, interview and document review the facility failed to protect a client from sexual abuse for 1 of 1 client (C1) review for abuse. The facility allowed C1 to leave the facility in the middle of the night to meet her boyfriend. C1 was sexually assaulted, videotaped on snap chat, and left stranded at a park. This resulted in an immediate jeopardy (IJ).	W 127	See next page, corrective action would not fit in this space.	4/15/22

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	24G435	A. BUILDING _____ B. WING _____	C 03/14/2022

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W 127	Continued From page 2 The IJ began on 2/20/22, when the facility failed to ensure safety of C1 who left the facility in the middle of the night and was sexually assaulted which was videotaped and placed on social media. The program supervisor was informed of the IJ on 3/11/22, at 5:11 p.m. The immediate jeopardy was removed on 3/14/22, at 4:06 p.m. when the facility's approved removal plan was verified onsite by the state agency. Findings include: C1's Client Face Sheet undated indicated she had diagnosis of mild to moderate intellectual disability, bipolar disorder, and fetal alcohol syndrome. C1's Crisis Stabilization Plan (CSP) dated 12/16/21, indicated she goes on dating sites and is quick to seek out men. The CSP indicated C1's plan to make safer decisions was to block phone numbers, delete sites, talk with staff, and talk with mom or grandmother. C1's Individual Abuse Prevention Plan (IAPP) dated 12/19/21, indicated she has a history of sexual abuse, and would not report abuse in a timely manner or to the appropriate authorities. A Facility Reported Incident (FRI) dated 2/22/22, indicated on 2/20/22, C1 asked for her medications to be packed for three days and told staff she was going to see her boyfriend at 3:00 a.m. and if wanted they could call her mother since she knows him. C1 never went to the boyfriend's apartment instead C1 and her boyfriend walked to a park where he asked for oral sex and C1 complied. C1 indicated she	W 127	Each resident's IAPP and ISP will be reviewed and the necessary changes will be made to ensure that all vulnerabilities are identified and a plan is in place. C1's IAPP will be reassessed and updated based on client's safety needs. Staff will be trained on the updated IAPP and new strategies for what to do if they are concerned about a situation or potential situation involving C1. Staff have also met with C1's care team to develop a plan for moving forward across different services. C1's Crisis Safety Plan will be updated to include preventative measures and other measures to better protect C1. Staff will be trained on each updated IAPP and ISP at the staff meeting. Program Leadership will ensure that employee training is complete and that completion is properly documented. Each IAPP will be reviewed and updated every 6 months, with the QIDAP approving the plan. The Program Manager will provide oversight and monthly auditing for the next quarter, then move to a semi-annual auditing process. **Owner:** Program Manager	4/15/22

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W 127	Continued From page 3 refused to have intercourse with her boyfriend, and he left her alone in the park. C1 did not have enough money for a transportation to get back to the facility, was crying, and called her mother for a ride. It was reported C1's boyfriend recorded the oral sex and put the recording on a social media platform, Snap Chat. During an interview on 3/08/22, at 2:00 p.m. program supervisor (PS) stated C1 is her own guardian and makes her own decisions. The facility is concerned about her making bad decisions but does not know what to do but try to discourage her from making those bad decisions. The PS stated the park police were called and they came out and filed a report. The PS stated the staff should have called the family or the support person but doubts they would have answered at 3:00 a.m. In addition, the program supervisor stated per her CSP, C1 is supposed to leave with a pull string alarm to use if she was in a bad situation. C1 could pull string and a loud alarm would go off; however, it was not sent with her that night. At a later interview, PS stated following the incident there was no investigation or re-training for staff to ensure the CSP was followed and C1 was more protected in the future. During an interview on 3/08/22, at 6:28 p.m. with C1 ' s family member who stated C1 does make her own decisions, but she is not making good ones. C1's family member stated they wished on the night of 2/20/22, the staff would have called her or her support person so they could have attempted to stop her from leaving the facility. The family member felt if they talked to her the incident probably never would have happened and stated, "nothing good happens after dark".	W 127		

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W 127	Continued From page 4 During an interview on 3/9/22, at 9:30 a.m. C1 stated on the night of 2/20/22, she called an Uber (taxi service) and went to meet her boyfriend and walked to a park where she performed oral sex while he tapped it. C1 then stated she does not want to talk about this anymore and walked away. During an interview on 3/10/22, at 1:34 p.m. mental health support specialist (MHSS)-A stated she was working the night of 2/20/22 and was informed by the evening shift her medications were packed for 3 days and she was going to her boyfriends. MHSS-A stated she thought it was ok to just let her leave even though it was 3:00 a.m. since she was her own guardian and decision maker. MHSS-A stated she never did call C1 ' s mother because she was never instructed to do so and was not aware that C1 was supposed to leave with a pull string alarm. MHSS-A stated she has left during the night shift while she had been working three other times. During an interview on 3/10/22, at 2:00 p.m. MHSS-B stated there was no education provided to prevent a reoccurrence related to C1 of C1's recent leaving on 2/20/22. In addition, MHSS-B stated he attended C1's TACT (Transition Age Community Treatment) team which was a program that provides community-based mental health services to adolescents and young adults who are struggling with functioning at home, in school, or in the community due to a serious mental health diagnosis. The TACT team also had concerns with C1 leaving and thinking this was unsafe. MHSS-B stated the TACT team meets with C1 weekly and was unsure what the TACT teams plan was to address the issue of C1 leaving.	W 127		

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W 127	Continued From page 5 The immediate jeopardy that began on 2/20/22, was removed on 3/14/22, at 4:06 p.m. when C1 was re-assessed for safety needs and updates to C1's Individual Abuse Prevention Plan and Crisis Safety Plan, staff training of the updates and verification of the training.	W 127		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the qualified intellectual disabilities professional (QIDP) had consistent oversight of each client's needs and individual program plans so that each client received the care and services needed to maintain their highest level of functioning for 5 of 5 clients (C1, C2, C3, C4 and C5) programs that were reviewed. Findings include: The QIDP failed to ensure the client's programs were individualized, monitored, and evaluated on an ongoing basis as follows: During an interview on 3/10/22, at 9:48 a.m. the program manager (PM) stated she and the program supervisor (PS) took over Peoples II (ICF) in October 2020 and there was no programing set up for the clients and they started working on setting up programing in January 2022 for the clients. The PM stated they were not collecting data and there was no implementation of goals, but they plan to start them going	W 159	A policy will be written identifying the QIDP, and the expectations of the role per the relevant statutory language. Staff will be trained on each updated QIDP policy at the staff meeting. Program Leadership will ensure that employee training is complete and that completion is properly documented. **Owner:** Operations Director	4/15/22

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W 159	Continued From page 6 forward. During an interview on 3/14/22, at 11:44 a.m. the vice president of operations stated the facility was completing the comprehensive functional assessments as required and there were goals for the clients. The vice president of operations stated it looks like we were not using the data forms like we should have been according to the program plans that were written. A policy was requested on role of QIDP but was not provided.	W 159		
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet the Condition of Participation of Active Treatment (42 CFR 483.440). Findings include: See W198: Thefacility failed to ensure clients living at the facility were in need of active treatment for 1 of 3 clients (C2) who were not assessed to require training and not currently receiving active treatment services. See W206. The facility failed to have individual program goals identified and implemented based on the clients needs 1 of 3 clients reviewed (C1)	W 195	The treatment and service policy will be reviewed and updated. Staff will be trained on the updated policy at the staff meeting. Program Leadership will ensure that employee training is complete and that completion is properly documented. **Owner:** Program Manager	4/15/22

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W 195	Continued From page 7 for active treatment. See W252. The facility failed to ensure that staff implemented programs and collected data according to the frequency identified in the Integrated Treatment Plan (ITP) so client programs could be monitored and revised based on client progress or regression for 1 of 3 clients (C3) reviewed for active treatment.	W 195		
W 198	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(1) Clients who are admitted by the facility must be in need of and receiving active treatment services. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to ensure clients living at the facility were in need of active treatment for 1 of 3 clients (C2) who were not assessed to require training and not currently receiving active treatment services. Findings include: C2's Client Face Sheet undated indicated C2 had mild intellectual disability,generalized anxiety disorder, major depression and panic disorder. C2's Comprehensive Functional Assessment (CFA) dated 11/2021, indicated C2 had no dietary needs, no mobility needs, has difficulty expressing emotions appropriately and engages in staff support in emotion regulation. The CFA further indicated under Skills Assessment she was independent in all areas of self care, home living skills, cooking skills, and with money	W 198	Program Manager will update the admission and discharge policies to ensure the facility is admitting appropriate clients who require Active Treatment as based on the clients' CFAs. Staff will be trained on the updated admission and discharge policies at the staff meeting. Program Leadership will ensure that employee training is complete and that completion is properly documented. QIDP will conduct quality assurance audits quarterly. C2 is currently at a different facility. A MNChoice Assessment for this client will be conducted at a later date, as C2's care team is working on further assessing C2's care needs. **Owner:** Program Manager	4/29/22

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W 198	Continued From page 8 management C2 has the understanding of the value of money is limited. The CFA indicated she needs no help in community skills, and with behavioral does have difficulty with decision making and staff does provide support. During interview on 3/14/22, at 10:00 a.m. program supervisor (PS) stated C2 has no active programing and never has since she had admitted to the facility approximately a year ago. The PS stated she frequently is staying at her boyfriend's place and is not at the home very often and they really don't do much for her. The PS stated the TACT (Transition Age Community Treatment) team which was a program that provides community-based mental health services to adolescents and young adults who are struggling with functioning at home, in school, or in the community due to a serious mental health diagnosis has been working with her and has goals they might work on, but the home has nothing to do with them. The PS stated they are now starting to track her days she is gone because they believe she has almost used her allowed time per year to be overnight out of the home which was approximately 75 days a year. During an interview 3/14/22, at 11:20 a.m. the PS stated although they are not working on any formal goal's for C2 to transition into the community C2 could be working on the following goals of money management, community activities, focus on self and not others. Review of C2's CFA did not identify evidence of areas C2 would have goals/programming developed with money management and community activities.	W 198		

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W 198	Continued From page 9 During an interview on 3/14/22, at 1:30 p.m. the PS stated the only goal they have for C2 was to track C2's appointments, apply for a job but they are not doing any formal data collection and are not racking her success in these goals to see if she has had any improvement. During an interview 3/14/22, at 3:00 p.m. program manager (PM) stated they are aware the programs need to be updated and to show if they are working and if they need to revise or update. In addition the PM stated C2 was admitted from one of there crisis units of People Inc. and C2 was not assessed correctly from the county to see if C2 was appropriate for placement at the home. The PM stated they are attempting to have C2 assessed and are unsure if she is appropriate to be placed at the facility. Facility Policy People II Active Treatment revised 10/16, indicated "It is the policy of People II to provide each individual with continuous active treatment according to federal and state regulations. Active treatment includes aggressive, consistent implementation of a program to specialized and general education, behavioral support, health, and related services. It enables the individuals to acquire and maintain behaviors and skills necessary to function at their maximum level of independence and self-determination."	W 198	Program Manager will verify that each client has completed treatment plan with established goals. Program Manager will work with any client who has a deficient treatment plan/CFA, such as C1, in order to establish goals. Staff will be trained on each updated IAPP at the staff meeting. Program Leadership will ensure that employee training is complete and that completion is properly documented. QIDP will conduct quality assurance audits at minimum on a quarterly basis. Audits are currently happening twice a week, but will be moving to every other week. Any needed changes or revisions will be discussed with the client's IDT members soon after. **Owner:** Program Manager	4/15/22
W 206	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to: (i) Identifying the client's needs, as described by	W 206		

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W 206	Continued From page 10 the comprehensive functional assessments required in paragraph (c)(3) of this section; and (ii) Designing programs that meet the client's needs. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to have individual program goals identified and implemented based on the clients needs 1 of 3 clients reviewed (C1) for active treatment. C1's Client Face Sheet undated indicated C1 had diagnosis of mild to moderate intellectual disability, bipolar disorder, and fetal alcohol syndrome. C1's Comprehensive Functional Assessment (CFA) dated 11/20/21, indicated she lacks motivation, memory and learning challenges. The CFA further indicated C1 is independent in self care, needs self prompts with home living skills, needs assist with money management, does not understand appropriate use of check card and had impulsive buying. C1's Integrated Treatment Plan (ITP) indicated C1 was open to several programs at People Incorporated, and currently lives at People II. The ITP further indicated she was also served by TACT (Transition Age Community Treatment) team which was a program that provides community-based mental health services to adolescents and young adults who are struggling with functioning at home, in school, or in the community due to a serious mental health diagnosis) and case management. The ITP indicated all programs currently share the same	W 206		

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W 206	Continued From page 11 treatment plan. Review of C1's ITP indicated the following programs: Employment: C1 struggles to have more independence, safely in the community and employment was identified as a way to explore her independence. Goal- TACT providers will meet with C1 weekly to discuss the barrier and maintaining employment Intervention: TACT will work to identify barrier, coach her on suitable skills, support in looking for employment that she can manage, and finally role play conflicts that may arise. Independent Living Skills: C1 would like to learn and practice independent living skills of budgeting, meal planning, healthy eating and self-care. Goal- C1 would like to learn and practice independent living skills of budgeting, meal planning, healthy eating and self care. Description- C1 will meet with staff to learn and practice skills of budgeting, making grocery lists, meal planning and learning and improving skills in the kitchen. Social Function: C1 trusts people too quickly and has gotten in trouble	W 206		

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W 206	Continued From page 12 Goal- C1 wants to learn to be more social with people and make more friends. Intervention: Meet with TACT workers to develop safe skills for making new friendships. Case management will meet with C1 monthly to review progress towards goal and discuss topics as needed. Review of C1's records lacked evidence above stated goals were implemented, documented or monitored for changes based on success or regression. During interview on 3/14/22, at 2:00 p.m. program supervisor (PS) stated Peoples II does not have programs written for C1 and they are not documenting any data towards meeting her goals except a progress note and this is not being reviewed. The PS stated they will be starting this moving forward. During interview on 3/14/22, at 2:10 p.m. vice president of operations (VPO) stated they will be meeting with her TACT team on Wednesday and they are working on making measurable goals for C1. The VPO stated the goals are not written with required frequencies and the only data they would have if the programs were being run would be in a progress note from the staff. Facility Policy People II Active Treatment revised 10/16, indicated "It is the policy of People II to provide each individual with continuous active treatment according to federal and state regulations. Active treatment includes aggressive, consistent implementation of a program to specialized and general education, behavioral support, health, and related services. It enables	W 206		

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W 206	Continued From page 13 the individuals to acquire and maintain behaviors and skills necessary to function at their maximum level of independence and self-determination."	W 206		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure that staff implemented programs and collected data according to the frequency identified in the Integrated Treatment Plan (ITP) so client programs could be monitored and revised based on client progress or regression for 1 of 3 clients (C3) reviewed for active treatment. Findings include: C3's Comprehensive Functional Assessment (CFA) dated 11/20/21, indicated C3 had Asperger's (significant difficulties in social interaction and nonverbal communication) , bipolar disorder and anxiety. The CFA further indicated C3 does not like to brush his teeth and can complete home living skills but may refuse. Review of C3's ITP indicated the following: Goal #1 I would like healthy teeth and gums so that I don't get cavities and have bad breath.	W 252	Data Collection data sheets will be created based on the current treatment goals established. Staff will be trained on the Data Collection data sheets at the staff meeting. Program Leadership will ensure that employee training is complete and that completion is properly documented. Program Supervisor will monitor the Data Collection data sheets on a bi-weekly basis to ensure data collection is being tracked for all established goals. QIDP will conduct quality assurance audits on a quarterly basis to ensure fulfillment of goals and that related data is being collected so client programs could be monitored and revised based on client progress or regression. **Owner:** Program Supervisor	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G435	A. BUILDING _____ B. WING _____	C 03/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEOPLE II	**1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419**

(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 252	Continued From page 14 Objective: C3 will brush his teeth twice each day. Baseline- This outcome will be consisted achieved when C2 is able to brush his teeth twice daily for an average success rate of 75% each month for 6 months. Staff were to use a tracking sheet using the following codes 0- declined, 1- completed outcome, 2- completed outcome with verbal assistance. 3- completed outcome with physical assistance, NA- outcome not completed. During interview 3/14/22, at 2:30 p.m. mental health support specialist (MHSS)-B stated they document once daily on electronic medical record if he brushed his teeth and are not using the codes. The MHSS-B stated he was not aware they were supposed to be documenting twice daily. The MHSS-B stated C3 almost always refuses. Goal #2 I would like to get better at keeping my clothes clean and put away. Objective: C3 will wash all of his laundry including bedding weekly. Baseline- This goal will be considered achieved when C3 washes and dries his clothes at least 75% of the Fridays each month for 3 consecutive months. Staff were to fill in that day on C3's goal tracking sheet using the following codes 0- declined X-	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 252	Continued From page 15 completed. During interview 3/14/22, at 2:35 p.m. MHSS-C stated C3 washes his clothes about once every other week and she documents this in a progress note and there is no data tracking sheet. During interview 3/14/22, at 3:00 p.m. PS stated C3 does not have a data tracking sheet and they are not tracking his progress towards this goal. People II Active Treatment Policy revised 10/16, indicated they use a structured format to include functional goals and objectives, which are specific, time-limited, observable and measurable.	W 252		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure employees wore appropriate personal protective equipment (PPE) to include eye protection in accordance with the Center of Disease Control (CDC) guidance. This had the potential to affect all five clients in the facility. Findings include: During an observation 3/08/22, at 2:00 p.m. the program supervisor (PS) and the float registered nurse (RN) were observed in the home with a surgical mask and no PPE eye protection on. In	W 455	Program Manager and Supervisor corrected this violation and staff were re-trained. Staff were also sent a reminder email. Program Manager and Supervisor will conduct and document random on-site staff observations to ensure Infection Control standards are successfully met. **Owner:** Program Supervisor.	3/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G435	A. BUILDING _____ B. WING _____	C 03/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEOPLE II	**1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419**

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W 455	Continued From page 16 addition, mental health support specialist (MHSS)-B was observed to be wearing a black cloth mask and no PPE eye protection on. MHSS-B was subsequently observed to be assisting the clients with snacks and talking with them thorough the home. During an observation and interview 3/09/22, at 9:33 a.m. the PS was observed to be wearing a surgical mask and no eye PPE on. In addition, MHSS-B was observed to be wearing a black cloth facial mask and no eye PPE. During interview, the PS stated they have been laxed on wearing the eye PPE and really have not been wearing them for months and informed MHSS-B to put on a surgical mask. During an interview 3/09/22 at 9:45 a.m. the MHSS-B stated during his orientation in January 2022, he was never informed he needed to wear eye PPE and had not been wearing them since he had started. Additionally, MHSS-B stated he has not noticed any of the staff wearing eye PPE. People Incorporated's COVID-19 Plan for Adult Foster Care/Community Residential Services-People II undated indicated People Incorporated will provide staff with surgical grade facial masks and face shields or eye goggles for protection.	W 455		