

Protecting, Maintaining and Improving the Health of All Minnesotans

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

#### People II

#### Page 2

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



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.

People Ii March 29, 2022 Page 2

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, 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: 03/29/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG			E SURVEY PLETED
		24G435	B. WING			C <b>03/14/2022</b>	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419		<u> </u>	14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
W 000	survey was comple complaint investigal compliance with 42 requirements for In Individuals with Interpretation of Classification of Classif	3/14/22, an abbreviated ted at your facility to conduct a tion. Your facility was not in CFR Part 483, subpart I, termediate Care Facilities for ellectual Disabilities.  Dlaints were found to be 1505 and MN81502) by was cited at W127.  Itient Protection 42 CFR not to be met. See W127.  20/22, when the facility failed C1 who left the facility in the was sexually assaulted, ced on social medial. The rewas informed of the IJ on the immediate jeopardy	W 0				
W 122	facility's approved ronsite by the state.  The Condition of Paservices 42 CFR 4 met. See W198, W In addition, the find cited.  Upon receipt of an onsite revisit of you validate that substate regulations has been CLIENT PROTECT.	articipation: Active Treatment 83.440 was found not to be 206 and W252.  ing of W159 and W455 were acceptable electronic POC, an ir facility may be conducted to intial compliance with the en attained.	W 1:	22 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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		240425	B. WING		С	
NAME OF F	PROVIDER OR SUPPLIER	24G435		TREET ADDRESS, CITY, STATE, ZIP CODE	03/1	4/2022
PEOPLE			1	380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID "	PROVIDER'S PLAN OF CORRECTION	u I	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
W 122	Continued From pa CFR(s): 483.420(a)	•	W 122			
W 127	The facility must en Therefore the facility This CONDITION is Based on interview Condition of Particip Client Protection was to protect 1 of 1 clies who was sexually as Findings include:  See W127: the facility as in the middle of the C1 was sexually as chat, and left strandan immediate jeoped PROTECTION OF CFR(s): 483.420(a)  The facility must en Therefore, the facility not subjected to phypsychological abuse This STANDARD is Based on observat review the facility fasexual abuse for 1 abuse. The facility as in the middle of the C1 was sexually as	sure the rights of all clients.  by must s not met as evidenced by: w and document review, the pation at 42 CFR 483.420 as not met. The facility failed ents (C1) from sexual abuse ssaulted.  ility failed to protect a client for 1 of 1 client (C1) review for allowed C1 to leave the facility night to meet her boyfriend. saulted, videotaped on snap ded at a park. This resulted in ardy (IJ).  CLIENTS RIGHTS  i(5)  sure the rights of all clients. ty must ensure that clients are ysical, verbal, sexual or e or punishment. s not met as evidenced by: ion, interview and document ailed to protect a client from of 1 client (C1) review for allowed C1 to leave the facility night to meet her boyfriend. saulted, videotaped on snap ded at a park. This resulted in	W 127			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPP/JEP/JEP/JEP

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G435	B. WING		03	C / <b>14/2022</b>
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)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 127	to ensure safety of middle of the night which was videotap media. The prograr the IJ on 3/11/22, a jeopardy was remowhen the facility's a verified onsite by the Findings include:  C1's Client Face Shad diagnosis of midisability, bipolar dissyndrome.  C1's Crisis Stabilization 12/16/21, indicated is quick to seek out plan to make safer numbers, delete sit mom or grandmoth C1's Individual Abundated 12/19/21, indicated indicated on 2/20/2 medications to be pataff she was going a.m. and if wanted since she knows his boyfriend's apartments boyfriend walked to since she knows his boyfriend walked to since	20/22, when the facility failed C1 who left the facility in the and was sexually assaulted bed and placed on social in supervisor was informed of t 5:11 p.m. The immediate wed on 3/14/22, at 4:06 p.m. approved removal plan was a state agency.  The eet undated indicated she all to moderate intellectual sorder, and fetal alcohol  Ation Plan (CSP) dated as he goes on dating sites and amen. The CSP indicated C1's decisions was to block phone es, talk with staff, and talk with er.  The eet undated indicated she are indicated C1's decisions was to block phone es, talk with staff, and talk with er.  The control plan (IAPP) icated she has a history of would not report abuse in a the appropriate authorities.  Incident (FRI) dated 2/22/22,	W 1	27		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		24G435	B. WING _			C 14/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	1 00/	14/2022
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 127	and he left her alor have enough mone back to the facility, mother for a ride. It recorded the oral se social media platfor.  During an interview program supervisor guardian and make facility is concerned decisions but does discourage her from The PS stated the pthey came out and the staff should have support person but answered at 3:00 a supervisor stated peleave with a pull stria bad situation. C1 alarm would go off; her that night. At all following the incider or re-training for stafollowed and C1 was During an interview C1's family member own decisions, ones. C1's family member on her support pattempted to stop her family member incident probably neighbor or probably n	precourse with her boyfriend, the in the park. C1 did not by for a transportation to get was crying, and called her was reported C1's boyfriend ex and put the recording on a	W 12	7		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G435	B. WING			C 14/2022
NAME OF I	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	1 00/	14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 127	stated on the night (taxi service) and w walked to a park why while he tapped it. O want to talk about the service mental health supposhe was working the informed by the every were packed for 3 oboyfriends. MHSS-A star mother because she was her of maker. MHSS-A star mother because she so and was not awaleave with a pull strip has left during their working three other.  During an interview MHSS-B stated the to prevent a reoccurrecent leaving on 2 stated he attended. Community Treatm program that proview health services to a who are struggling school, or in the commental health diagriphad concerns with O was unsafe. MHSS meets with C1 wee	on 3/9/22, at 9:30 a.m. C1 of 2/20/22, she called an Uber ent to meet her boyfriend and here she performed oral sex C1 then stated she does not his anymore and walked away.  on 3/10/22, at 1:34 p.m. ort specialist (MHSS)-A stated enight of 2/20/22 and was ening shift her medications days and she was going to her A stated she thought it was ok even though it was 3:00 a.m. own guardian and decision ated she never did call C1's e was never instructed to do are that C1 was supposed to ing alarm. MHSS-A stated she night shift while she had been	W 127			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		24G435	B. WING	;		C <b>03/14/2022</b>	
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 380 WEST MINNEHAHA PARKWAY	, 55/	
PEOPLE	II .			N	MINNEAPOLIS, MN 55419		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 127	Continued From pa	ge 5	W 1	127			
W 159	was removed on 3/ was re-assessed for C1's Individual Abus Safety Plan, staff tra verification of the tra		W	159			
	integrated, coordinate qualified intellectual This STANDARD is Based on observate review, the facility faintellectual disabilitic consistent oversigh individual program received the care a maintain their higher	treatment program must be ated and monitored by a I disability professional whos not met as evidenced by: ion, interview and document ailed to ensure the qualified es professional (QIDP) had to feach client's needs and plans so that each client nd services needed to est level of functioning for 5 of 3, C4 and C5) programs that					
	Findings include:						
		ensure the client's programs , monitored, and evaluated on s follows:					
	program manager (program supervisor (ICF) in October 20 programing set up f working on setting a 2022 for the clients collecting data and	on 3/10/22, at 9:48 a.m. the PM) stated she and the (PS) took over Peoples II 20 and there was no for the clients and they started up programing in January. The PM stated they were not there was no implementation an to start them going					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24G435	B. WING				C 1 <b>4/2022</b>
NAME OF F	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	<u>, 007</u>	14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 159	vice president of op	ge 6 on 3/14/22, at 11:44 a.m. the erations stated the facility was aprehensive functional	W 1	159			
	assessments as rec for the clients. The stated it looks like v	quired and there were goals vice president of operations we were not using the data d have been according to the					
W 195	A policy was reques not provided. ACTIVE TREATME CFR(s): 483.440	sted on role of QIDP but was	W 1	195			
		sure that specific active requirements are met.					
	Based on observat review, the facility fa	s not met as evidenced by: ion, interview, and document ailed to meet the Condition of ve Treatment (42 CFR					
	Findings include:						
	living at the facility value treatment for 1 of 3	were in need of active clients (C2) who were not training and not currently atment services.					
	program goals iden	cility failed to have individual tified and implemented based in 1 of 3 clients reviewed (C1)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
			A. BOILDI		С	
		24G435	B. WING		03/14/20	)22
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419		
	011111111111111111111111111111111111111	TELEVIT OF REFIGIENCES			1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COM	(X5) PLETION DATE
W 195	Continued From pa	_	W 1	95		
W 198	implemented progra according to the fre Integrated Treatme programs could be on client progress of (C3) reviewed for a	ANSFERS, DISCHARGE	W 1	98		
		mitted by the facility must be in ng active treatment services.				
	Based on interview facility failed to ensi- were in need of acti (C2) who were not a	s not met as evidenced by:  and document review the ure clients living at the facility ive treatment for 1 of 3 clients assessed to require training iceiving active treatment				
	Findings include:					
	mild intellectual disa	neet undated indicated C2 had ability,generalized anxiety pression and panic disorder.				
	(CFA) dated 11/202 needs, no mobility r expressing emotion in staff support in ef further indicated un was independent in	ve Functional Assessment 11, indicated C2 had no dietary needs, has difficulty as appropriately and engages motion regulation. The CFA der Skills Assessment she all areas of self care, home a skills, and with money				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G435	B. WING _			C <b>14/2022</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	1 00/	14/2022
(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 APPROPROFICIENCY)	) BE	(X5) COMPLETION DATE
W 198	management C2 havalue of money is lineeds no help in cobehavioral does have making and staff do During interview on program supervisor programing and nevadmitted to the faci. The PS stated she boyfriend's place ar often and they reall PS stated the TACT Treatment) team who provides community services to adolesc struggling with funcin the community diagnosis has been goals they might wo nothing to do with the now starting to trace because they believe allowed time per yellowed	as the understanding of the mited. The CFA indicated she mmunity skills, and with we difficulty with decision pes provide support.  3/14/22, at 10:00 a.m. (PS) stated C2 has no active wer has since she had lity approximately a year ago. frequently is staying at her and is not at the home very y don't do much for her. The (Transition Age Community hich was a program that y-based mental health ents and young adults who are tioning at home, in school, or ue to a serious mental health working with her and has brewn. The PS stated they are kner days she is gone are to be overnight out of the proximately 75 days a year.  3/14/22, at 11:20 a.m. the PS y are not working on any at to transition into the dome to the working on the following magement, community self and not others.  A did not identify evidence of a goals/programming ney management and	W 19			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		24G435	B. WING		C <b>03/14/</b> 2	2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	j 03/14/ <i>2</i>	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 CO	(X5) DMPLETION DATE
W 198	During an interview PS stated the only of track C2's appointing any form of racking her such she has had any important the programs of the programs need to be are working and if the light one of there crisis to was not assessed of see if C2 was approhome. The PM states	on 3/14/22, at 1:30 p.m. the goal they have for C2 was to nents, apply for a job but they ormal data collection and are cess in these goals to see if approvement.  3/14/22, at 3:00 p.m. programed they are aware the peed to revise or update. Stated C2 was admitted from units of People Inc. and C2 correctly from the county to opriate for placement at the ted they are attempting to and are unsure if she is	W 198	3		
W 206	10/16, indicated "It provide each individe treatment according regulations. Active consistent impleme specialized and ger support, health, and the individuals to accord and skills necessar level of independent INDIVIDUAL PROCETR(s): 483.440(c)  Each client must have developed by an interpresents the professor areas that are relevant to the provided to the professor and the professor areas that are relevant according to the provided to the professor areas that are relevant according to the provided to the	(1)  ave an individual program plan erdisciplinary team that essions, disciplines or service	W 200			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		24G435	B. WING	i			C <b>14/2022</b>
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE 380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	<u>  00/</u>	14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 206	the comprehensive required in paragra	ge 10 functional assessments ph (c)(3) of this section; and rams that meet the client's	W:	206			
	Based on interview facility failed to have identified and imple	s not met as evidenced by:  y and document review the e individual program goals mented based on the clients reviewed (C1) for active					
	had diagnosis of m	neet undated indicated C1 ild to moderate intellectual sorder, and fetal alcohol					
	(CFA) dated 11/20/2 motivation, memory The CFA further ind self care, needs se skills, needs assist	ve Functional Assessment 21, indicated she lacks v and learning challenges. licated C1 is independent in 1f prompts with home living with money management, d appropriate use of check sive buying.					
	C1 was open to set Incorporated, and of ITP further indicate TACT (Transition Acteam which was a promunity-based radolescents and you with functioning at 1 community due to a diagnosis) and case	atment Plan (ITP) indicated veral programs at People currently lives at People II. The d she was also served by ge Community Treatment) program that provides mental health services to ung adults who are struggling nome, in school, or in the a serious mental health e management. The ITP ms currently share the same					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION  S		SURVEY PLETED
		240425	B. WING		(	
NAME OF F	PROVIDER OR SUPPLIER	24G435		STREET ADDRESS, CITY, STATE, ZIP CODE	03/1	14/2022
NAME OF F	PROVIDER OR SUPPLIER			1380 WEST MINNEHAHA PARKWAY		
PEOPLE	II			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 206	Continued From pa treatment plan.	ge 11	W 206	3		
	Review of C1's ITP programs:	indicated the following				
	in the community a	ve more independence, safely nd employment was identified her independence.				
	Goal- TACT providers will meet with C1 weekly to discuss the barrier and maintaining employment					
	coach her on suitab	will work to identify barrier, ble skills, support in looking for ne can manage, and finally role nay arise.				
	Independent Living	Skills:				
		arn and practice independent eting, meal planning, healthy				
		e to learn and practice skills of budgeting, meal ating and self care.				
	practice skills of bu	meet with staff to learn and dgeting, making grocery lists, learning and improving skills in				
	Social Function:					
	C1 trusts people too trouble	o quickly and has gotten in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		24G435	B. WING _			14/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 206	people and make n Intervention: Meet v safe skills for makin management will m	earn to be more social with	W 20	6		
	stated goals were in	ords lacked evidence above mplemented, documented or ges based on success or				
	supervisor (PS) sta programs written fo documenting any d except a progress r	3/14/22, at 2:00 p.m. program ted Peoples II does not have or C1 and they are not ata towards meeting her goals note and this is not being stated they will be starting this				
	president of operati meeting with her TA they are working or C1. The VPO state with required freque	3/14/22, at 2:10 p.m. vice ons (VPO) stated they will be ACT team on Wednesday and making measurable goals for ed the goals are not written encies and the only data they rograms were being run would the from the staff.				
	10/16, indicated "It provide each individe treatment according regulations. Active consistent implements specialized and ger	le II Active Treatment revised is the policy of People II to dual with continuous active g to federal and state treatment includes aggressive, entation of a program to neral education, behavioral d related services. It enables				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		24G435	B. WING			C <b>14/2022</b>
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	14/2022
				1380 WEST MINNEHAHA PARKWAY		
PEOPLE	II			MINNEAPOLIS, MN 55419		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUNDS OF THE APPR  CROSS-REFERENCED TO THE APPR  DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 206		•	W 2	206		
W 252	the individuals to acquire and maintain behaviors and skills necessary to function at their maximum level of independence and self-determination." PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1)		W 2	252		
	specified in client in	omplishment of the criteria dividual program plan documented in measurable				
	Based on interview facility failed to ensu programs and colle frequency identified Plan (ITP) so client and revised based of	s not met as evidenced by:  y and document review, the ure that staff implemented cted data according to the in the Integrated Treatment programs could be monitored on client progress or 3 clients (C3) reviewed for				
	Findings include:					
	(CFA) dated 11/20/2 Asperger's (signification and non- bipolar disorder and indicated C3 does r	re Functional Assessment 21, indicated C3 had ant difficulties in social verbal communication), d anxiety. The CFA further not like to brush his teeth and e living skills but may refuse.				
	Review of C3's ITP	indicated the following:				
	Goal #1 I would like healthy get cavities and hav	teeth and gums so that I don't ve bad breath.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		24G435	B. WING		03	C /14/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419		114/2022
(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 252	Continued From pa	ge 14	W 2	252		
	Objective: C3 will b	rush his teeth twice each day.				
	achieved when C2	ome will be consisted is able to brush his teeth twice success rate of 75% each				
	following codes 0- outcome, 2- compleassistance. 3- compleassistance.	e to use a tracking sheet using the codes 0- declined, 1- completed 2- completed outcome with verbal e. 3- completed outcome with physical e, NA- outcome not completed.				
	health support spec document once dai if he brushed his te codes. The MHSS they were supposed	14/22, at 2:30 p.m. mental sialist (MHSS)-B stated they ly on electronic medical record eth and are not using the -B stated he was not aware d to be documenting twice stated C3 almost always				
	Goal #2					
	I would like to get b clean and put away	etter at keeping my clothes				
	Objective: C3 will w bedding weekly.	ash all of his laundry including				
	when C3 washes a	will be considered achieved nd dries his clothes at least each month for 3 consecutive				
		hat day on C3's goal tracking owing codes 0- declined X-				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24G435	B. WING	i			C 1 <b>4/2022</b>
NAME OF F	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	<u> </u>	14/2022
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 252	Continued From pa completed.	ge 15	W 2	252			
	stated C3 washes hother week and she note and there is no During interview 3/1	4/22, at 2:35 p.m. MHSS-C his clothes about once every documents this in a progress o data tracking sheet.  4/22, at 3:00 p.m. PS stated					
W 455	are not tracking his People II Active Tre indicated they use a functional goals and specific, time-limite measurable.		W 4	455			
	CFR(s): 483.470(I)(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.						
	program supervisor	on 3/08/22, at 2:00 p.m. the (PS) and the float registered eserved in the home with a					
		no PPE eye protection on. In					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24G435	B. WING	;			C <b>14/2022</b>
NAME OF F	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	1 00/	1472022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
W 455	addition, mental hea (MHSS)-B was obseloth mask and no MHSS-B was subseassisting the clients them thorough the I During an observation of the surgical mask and MHSS-B was obseloth facial mask ar interview, the PS stometries was interview, the PS stometries was not on a surgical During an interview MHSS-B stated dur 2022, he was never eye PPE and had not noticed any People Incorporate Foster Care/Comm Services-People II I Incorporated will proceed the subsection of the subsect	alth support specialist erved to be wearing a black PPE eye protection on. equently observed to be with snacks and talking with nome.  Ion and interview 3/09/22, at as observed to be wearing a no eye PPE on. In addition, rved to be wearing a black no no eye PPE. During ated they have been laxed on E and really have not been onths and informed MHSS-B mask.  3/09/22 at 9:45 a.m. the ing his orientation in January informed he needed to wear ot been wearing them since littionally, MHSS-B stated he of the staff wearing eye PPE.	W	455			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			
		01556	B. WING		03/1	4/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PEOPLE	: II		ST 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 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 Departments of the Minnesota Departments of the Minnesota MN Ruindicated below. We several items, failuritems will be considered the corrected during the corrected.  You may request a that may result from orders provided that the Department with notice of assessment of a fire violated during the corrected.  You may request a that may result from orders provided that the Department with notice of assessment of a fire violated during the corrected.  You may request a that may result from orders provided that the Department with notice of assessment of a fire violated during the corrected.  The following composures and the following composures of the following composures and the following composures are following composures and the following composures are following composures.	hether a violation has been compliance with all erule provided at the tag alle number or MN Statute. Then a rule or statute contains the to comply with any of the dered lack of compliance. The upon re-inspection with any alle will result in the the 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 the hin 15 days of receipt of a tent for non-compliance. The inducted of t	5 000			

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

TITLE (X6) DATE



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, 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

PRINTED: 05/19/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		E SURVEY PLETED
							-C
		24G435	B. WING	_		05/	02/2022
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
DEODLE	п			1	1380 WEST MINNEHAHA PARKWAY		
PEOPLE	II			I	MINNEAPOLIS, MN 55419		
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 000}		Susie Haben te revisit was conducted to	(W 00	00}	received 5/25/22 approved 5/25/22 POC 6/9/22		
W 237	follow up on deficie abbreviated survey was found to be not requirements of 42 Intermediate Care Fintellectual Disabilit.  Upon receipt of an a onsite revisit of you validate that substate regulations has been INDIVIDUAL PROCEFR(s): 483.440(c)  Each written training implement the object program plan must frequency of data or to assess progress. This STANDARD is Based on interview.	ncies related to a standard exited 3/14/22. The facility t in compliance with the CFR 483. Subpart I, for facilities for Individuals with ies (ICF/IID.)  acceptable electronic POC, an r facility may be conducted to intial compliance with the en attained.  BRAM PLAN	W 2	237	1. The treatment plan format has been updated to include data and data collection requirements.  2. Client's treatment plan and goa were updated to include specific of and frequency of data collection.  3. All clients' treatment plans and goals will be reviewed and update necessary  4. Staff will be retrained on all client 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	als data ed if ent's ed	6/9/2022
	data collection to as desired goals for 3	eviewed for active treatment.			the completion of this plan.	-	
	Findings include:						
	(CFA) dated 11/20/2 depression disorded The CFA further ind medications, had m challenges, vulnera understand value of	ve Functional Assessment 21, indicated C1 had major r and binge eating disorder. licated staff administered her rood disorder with learning ble with money doesn't f money with impulsive					
I ABORATORY		FR/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE		TITI F		(X6) DA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Compliance Coordinator

5/25/2022

Any defice continued 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.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		24G435	B. WING	)			-C <b>02/2022</b>
PEOPLE	PROVIDER OR SUPPLIER			13	TREET ADDRESS, CITY, STATE, ZIP CODE 380 WEST MINNEHAHA PARKWAY IINNEAPOLIS, MN 55419	, 00,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 237	seeking unknown's CFA indicated staff Review of C1's Projection of C1's Indicated C1 will select options) when feeling Staff were provided initial daily under AN Area: Self Care Goal: C1 will use methree full nights per Staff were provided initial daily under AN Area: Safety Plan Goal: C1 will meet with plan when C1 was Indicated C1 will meet with budget.  C1's goal did not interest of C1's goal was to be an averbal cues or could goals also did not interest of C2's CFA dated 11/1 bipolar disorder and indicated C2 does arrequired daily reminifust won't due it", as	ggression and sexual behavior afe partners. In addition the support medical health.  gram Goals dated April 2022 ing goals:  n Coping Skills from coping skills (3 identified ng angry. Staff will prompt. a calendar where the would of or PM if the task occurred.	W	237			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G435	B. WING				-C
NAME OF I	PROVIDER OR SUPPLIER	240400	J. Wille	S 1	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	05/1	02/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 237	Continued From pa	ge 2	W 2	237			
	Review of C2's Pro indicated the follow	gram Goals dated April 2022 ing goals:					
		ependent Living Capacity room weekly (clothes picked					
	Area: Self Care/Ind Goal: Staff will pron	ependent Living npt weekly to wash clothes					
	Area:Finance Goal: C2 will meet budget.	with staff weekly to review					
	Area:Self Care/Inde Goal: Will brush his	ependent Living steeth two times a week					
	the goal was to be verbal cues or could goals also did not id	dicate what day of the week ran and if C2 needed prompts, d do them independently. The dentify how they would be ogress would be determined.					
	Review of C3's reco	ord indicated C3 did not have					
	Review of C3's Pro indicated the follow	gram Goals dated April 2022 ing goals:					
	Area: Financial Goal: C3 will meet review budgets.	with staff on a weekly basis to					
		ependent Living Capacity npt C3 to bathe every other					
	Area: Self Care/Ind	ependent Living Capacity					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		24G435	B. WING			R-C / <b>02/2022</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPIDEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 237	laundry  Area: Self Care/Ind Goal: I will meet wi cooking.  C3's goals did not in the goals were to be prompts, verbal cue independently. The they 'Il would be trabe determined. In a CFA to find needs on.  During interview on manager (PM) state according to the clie the regulation configoals written lacked progression and shithe goals such as we completed, percent track from month to The PM stated she the goals immediate.  People II Active Treindicated they use as	ependent Living Capacity th staff weekly to practice my  Indicate what day of the week e ran and if C3 needed es or could do them goals also did not identify how acked and how progress would addition C3 lacked to have a or goals C3 should be working  5/2/22, at 11:55 a.m. program ed the goals were set up ent needs and after review of rmed an understanding the d to have ways to track ould have more information in when they should be ages to achieve so they could of month and include a rational. will be working on changing ely.  eatment Policy revised 10/16, a structured format to include d objectives, which are	W 2	37		

PRINTED: 03/29/2022 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24G435	B. WING_		C	000
NAME OF S	200//050 00 01/00/150	240433	D. WING _	OTDEST ADDRESS SITV STATE 71D SODE	03/14/20	022
PEOPLE	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) IPLETION DATE
W 000	survey was comple	3/14/22, an abbreviated ted at your facility to conduct a	W 00	0		
	compliance with 42	tion. Your facility was not in CFR Part 483, subpart I, termediate Care Facilities for ellectual Disabilities.				
	SUBSTANTIATED: HG435025C (MN8 <sup>2</sup>	laints were found to be 1505 and MN81502) Iy was cited at W127.		Susie Haben		
		ient Protection 42 CFR not to be met. See W127.		POC 4/29/22 reviewed and approved 4/21	/22	
	to ensure safety of middle of the night, videotaped and place program supervisor 3/11/22, at 5:11 p.m was removed on 3/	20/22, when the facility failed C1 who left the facility in the was sexually assaulted, ced on social medial. The was informed of the IJ on The immediate jeopardy 14/22, at 4:06 p.m. when the emoval plan was verified agency.				
		articipation: Active Treatment 83.440 was found not to be 206 and W252.				
	In addition, the findicited.	ing of W159 and W455 were				
	onsite revisit of you validate that substa regulations has been					
W 122		IONS	W 12	2	(Xe) D	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE.

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G435	B. WING		(	
NAME OF F	PROVIDER OR SUPPLIER	246455		STREET ADDRESS, CITY, STATE, ZIP CODE	03/1	14/2022
IVAIVIL OI I	NOVIDEN ON OUT LIEN			1380 WEST MINNEHAHA PARKWAY		
PEOPLE	II			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 122	CFR(s): 483.420(a) The facility must en Therefore the facilit This CONDITION i Based on interview Condition of Particip Client Protection was to protect 1 of 1 clie who was sexually a Findings include: See W127: the fac	sure the rights of all clients. y must s not met as evidenced by: v and document review, the pation at 42 CFR 483.420 as not met. The facility failed ents (C1) from sexual abuse	W 122	Each resident's IAPP will be reviewed the necessary changes will be made ensure that all vulnerabilities are ideand a plan is in place. Staff will be to on each updated IAPP at the staff meeting. Program Leadership will ensure that employee training is complete, that completion is properly documer Each IAPP will be reviewed and updevery 6 months, with the QIDAP approving the plan. The Program Manager will provide oversight and monthly auditing for the next quarter move to a semi-annual auditing process.	e to entified rained nsure and nted. dated	4/15/22
W 127	abuse. The facility as in the middle of the C1 was sexually as chat, and left strand an immediate jeopa PROTECTION OF CFR(s): 483.420(a)  The facility must en Therefore, the facility not subjected to physychological abuse. This STANDARD is Based on observat review the facility fasexual abuse for 1 abuse. The facility as in the middle of the C1 was sexually as	allowed C1 to leave the facility night to meet her boyfriend. saulted, videotaped on snap led at a park. This resulted in ardy (IJ). CLIENTS RIGHTS (5) sure the rights of all clients. ty must ensure that clients are ysical, verbal, sexual or e or punishment. In the or punishment in the or protect a client from of 1 client (C1) review for allowed C1 to leave the facility night to meet her boyfriend. In the or park, in the or park, in the or possible of	W 127	See next page, corrective action we not fit in this space.	ould	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24G435	B. WING			C <b>03/14/2022</b>	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	•	14/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 127	The IJ began on 2/2 to ensure safety of middle of the night which was videotap media. The program the IJ on 3/11/22, a jeopardy was remowhen the facility's a verified onsite by the Findings include:  C1's Client Face Shad diagnosis of midisability, bipolar dissyndrome.  C1's Crisis Stabilization 12/16/21, indicated is quick to seek out plan to make safer numbers, delete sit mom or grandmoth  C1's Individual Abundated 12/19/21, indicated indicated on 2/20/21 medications to be pataff she was going a.m. and if wanted since she knows his boyfriend's apartments of the safety of the safety of the safety of medications to be pataff she was going a.m. and if wanted since she knows his boyfriend's apartments of the safety of the	20/22, when the facility failed C1 who left the facility in the and was sexually assaulted ed and placed on social in supervisor was informed of t 5:11 p.m. The immediate wed on 3/14/22, at 4:06 p.m. pproved removal plan was e state agency.  The est undated indicated she lid to moderate intellectual sorder, and fetal alcohol  Ation Plan (CSP) dated she goes on dating sites and men. The CSP indicated C1's decisions was to block phone es, talk with staff, and talk with er.  The est Prevention Plan (IAPP) icated she has a history of would not report abuse in a the appropriate authorities.  Incident (FRI) dated 2/22/22,	W 12	Each resident's IAPP and ISP or reviewed and the necessary che be made to ensure that all vulnare identified and a plan is in place identified and updated IAPP strategies for what to do if they concerned about a situation or situation involving C1. Staff have met with C1's care team to deviplan for moving forward across services. C1's Crisis Safety Place updated to include preventative measures and other measures protect C1. Staff will be trained updated IAPP and ISP at the simeeting. Program Leadership wensure that employee training it complete and that completion is documented. Each IAPP will be reviewed and updated every 6 with the QIDAP approving the program Manager will provide and monthly auditing for the nequarter, then move to a semi-a auditing process.  Owner: Program Manager  Owner: Program Manager	anges will erabilities ace. C1's odated Staff will and new are potential re also elop a different n will be to better on each aff will s properly months, blan. The oversight	4/15/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G435	B. WING _			C 14/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	1 00/	14/2022
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 127	and he left her alor have enough mone back to the facility, mother for a ride. It recorded the oral se social media platfor.  During an interview program supervisor guardian and make facility is concerned decisions but does discourage her from The PS stated the pthey came out and the staff should have support person but answered at 3:00 a supervisor stated peleave with a pull stria bad situation. C1 alarm would go off; her that night. At all following the incider or re-training for stafollowed and C1 was During an interview C1's family member own decisions, ones. C1's family member on her support pattempted to stop her family member incident probably neighbor or probably n	recourse with her boyfriend, he in the park. C1 did not y for a transportation to get was crying, and called her was reported C1's boyfriend ex and put the recording on a	W 12	7		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	24G435		B. WING		C <b>03/14/2022</b>	
NAME OF PROVIDER OR SUPPLIER  PEOPLE II				STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	US/	14/2022
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 127	stated on the night (taxi service) and w walked to a park wh while he tapped it. O want to talk about the service mental health supposhe was working the informed by the every were packed for 3 composition books books and was here of maker. MHSS-A star mother because she so and was not awaleave with a pull strip has left during the reworking three other.  During an interview MHSS-B stated the to prevent a reoccurrecent leaving on 2 stated he attended. Community Treatmore program that proview the alth services to a who are struggling school, or in the commental health diagriph had concerns with O was unsafe. MHSS meets with C1 week.	on 3/9/22, at 9:30 a.m. C1 of 2/20/22, she called an Uber tent to meet her boyfriend and here she performed oral sex C1 then stated she does not his anymore and walked away.  on 3/10/22, at 1:34 p.m. ort specialist (MHSS)-A stated enight of 2/20/22 and was ening shift her medications days and she was going to her A stated she thought it was ok even though it was 3:00 a.m. own guardian and decision ated she never did call C1's e was never instructed to do are that C1 was supposed to ing alarm. MHSS-A stated she hight shift while she had been	W 127			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
24G435			B. WING		03/14/2022	
PEOPLE	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 380 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 127	was removed on 3/ was re-assessed for C1's Individual Abus Safety Plan, staff tra verification of the tra	oardy that began on 2/20/22, 14/22, at 4:06 p.m. when C1 or safety needs and updates to se Prevention Plan and Crisis aining of the updates and	W 127			
W 159	integrated, coordinate qualified intellectual This STANDARD is Based on observate review, the facility faintellectual disabiliticonsistent oversigh individual program preceived the care a maintain their highes 5 clients (C1, C2, C) were reviewed.  Findings include:  The QIDP failed to were individualized, an ongoing basis as During an interview program manager (program supervisor (ICF) in October 20 programing set up for working on setting use 2022 for the clients collecting data and	treatment program must be ated and monitored by a disability professional whose not met as evidenced by: ion, interview and document ailed to ensure the qualified es professional (QIDP) had to feach client's needs and plans so that each client and services needed to est level of functioning for 5 of 3, C4 and C5) programs that ensure the client's programs monitored, and evaluated on	W 159	A policy will be written identifying the QIDP, and the expectations of the rether relevant statutory language. State trained on each updated QIDP per the staff meeting. Program Leaders ensure that employee training is contained that completion is properly documented.  Owner: Operations Director	ole per ff will olicy at nip will	4/15/22

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		040405				С	
		24G435	B. WING _		03/	14/2022	
PEOPLE	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)  SUMMARY STATEMENT OF DEFICIENCIES  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETION DATE		
W 159	vice president of op	ge 6 on 3/14/22, at 11:44 a.m. the perations stated the facility was aprehensive functional	W 15	9			
	assessments as rec for the clients. The stated it looks like v	quired and there were goals vice president of operations we were not using the data d have been according to the					
W 195	CFR(s): 483.440  The facility must ensure that specific active treatment services requirements are met.		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		4/15/22		
	Based on observat review, the facility fa	s not met as evidenced by: ion, interview, and document ailed to meet the Condition of ve Treatment (42 CFR		properly documented.  Owner: Program Manager			
	Findings include:						
	living at the facility treatment for 1 of 3	ility failed to ensure clients were in need of active clients (C2) who were not training and not currently atment services.					
	program goals iden	cility failed to have individual tified and implemented based s 1 of 3 clients reviewed (C1)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
	<b>24G435</b> B. WING				C <b>03/14/2022</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	1-4/2-022
PEOPLE	II			1380 WEST MINNEHAHA PARKWAY 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 195	for active treatment See W252. The facing implemented prograte according to the free Integrated Treatment programs could be	cility failed to ensure that staff ams and collected data quency identified in the nt Plan (ITP) so client monitored and revised based	W 195			
W 198	(C3) reviewed for an ADMISSIONS, TRACCFR(s): 483.440(b) Clients who are adr	ANSFERS, DISCHARGE	W 198	Program Manager will update the admission and discharge policies to ensure the facility is admitting appropriate clients who require Activate Treatment as based on the clients' CFAs. Staff will be trained on the		4/29/22
	Based on interview facility failed to ensure were in need of acti (C2) who were not and not currently reservices.  Findings include:	s not met as evidenced by:  and document review the ure clients living at the facility ive treatment for 1 of 3 clients assessed to require training ceiving active treatment		updated admission and discharge policies at the staff meeting. Prograi Leadership will ensure that employe training is complete and that complete properly documented. QIDP will conduct quality assurance audits quarterly.  C2 is currently at a different facility. MNChoice Assessment for this clier be conducted at a later date, as C2'	etion A at will	
	mild intellectual disa disorder, major dep C2's Comprehensiv (CFA) dated 11/202 needs, no mobility r expressing emotion in staff support in er further indicated un was independent in	neet undated indicated C2 had ability,generalized anxiety ression and panic disorder.  We Functional Assessment 1, indicated C2 had no dietary needs, has difficulty as appropriately and engages motion regulation. The CFA der Skills Assessment she all areas of self care, home y skills, and with money		care team is working on further assessing C2's care needs.  Owner: Program Manager		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
24G435			B. WING			C 1 <b>4/2022</b>
NAME OF PROVIDER OR SUPPLIER  PEOPLE II			1	TREET ADDRESS, CITY, STATE, ZIP CODE 380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	1 00/	14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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 198	value of money is lineeds no help in cobehavioral does have making and staff do During interview on program supervisor programing and nevadmitted to the facil The PS stated she boyfriend's place ar often and they reall: PS stated the TACT Treatment) team who provides community services to adolesc struggling with funcin the community didiagnosis has been goals they might wo nothing to do with the now starting to track because they believed allowed time per yellowed time per ye	as the understanding of the mited. The CFA indicated she immunity skills, and with we difficulty with decision pes provide support.  3/14/22, at 10:00 a.m. (PS) stated C2 has no active wer has since she had lity approximately a year ago. frequently is staying at her and is not at the home very y don't do much for her. The (Transition Age Community hich was a program that y-based mental health ents and young adults who are tioning at home, in school, or ue to a serious mental health working with her and has brik on, but the home has hem. The PS stated they are kner days she is gone are she has almost used her are to be overnight out of the proximately 75 days a year.  3/14/22, at 11:20 a.m. the PS y are not working on any to transition into the do be working on the following magement, community self and not others.	W 198			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	24G435			B. WING		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	03/14/2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
	PS stated the only of track C2's appointmare not doing any for not racking her such she has had any important and skills necessarilevel of independent INDIVIDUAL PROCETR(s): 483.440(c)  Each client must have developed by an interpresents the profession and any important any importa	on 3/14/22, at 1:30 p.m. the goal they have for C2 was to nents, apply for a job but they ormal data collection and are cess in these goals to see if provement.  3/14/22, at 3:00 p.m. program ed they are aware the see updated and to show if they hey need to revise or update. Stated C2 was admitted from units of People Inc. and C2 correctly from the county to opriate for placement at the ted they are attempting to and are unsure if she is aced at the facility.  Ile II Active Treatment revised is the policy of People II to dual with continuous active go to federal and state treatment includes aggressive, intation of a program to neral education, behavioral direlated services. It enables equire and maintain behaviors by to function at their maximum ince and self-determination."  SRAM PLAN  (1)  Ave an individual program plan erdisciplinary team that essions, disciplines or service	W 198	Program Manager will verify that eclient has completed treatment pla with established goals. Program Manager will work with any client whas a deficient treatment plan/CFA such as C1, in order to establish goals. Staff will be trained on each update IAPP at the staff meeting. Program Leadership will ensure that employ training is complete and that completion is properly documented OIDP will conduct quality assurance.	yho yho a, pals. ed n yee d. 4/15/22 be pasis. be a other	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED		
24G435		B. WING		C <b>03/14/2022</b>		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 WEST MINNEHAHA PARKWAY MINNEAPOLIS, MN 55419	1 03/14	72022
(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 CROSS-REFERENCED TO THE APPROP	BE C	(X5) COMPLETION DATE
W 206	the comprehensive required in paragra	ge 10 functional assessments oh (c)(3) of this section; and rams that meet the client's	W 200	6		
	Based on interview facility failed to have identified and imple	s not met as evidenced by:  y and document review the e individual program goals mented based on the clients reviewed (C1) for active				
	C1's Client Face Sheet undated indicated C1 had diagnosis of mild to moderate intellectual disability, bipolar disorder, and fetal alcohol syndrome.					
	(CFA) dated 11/20/2 motivation, memory The CFA further inc self care, needs sel skills, needs assist	re Functional Assessment 21, indicated she lacks and learning challenges. licated C1 is independent in f prompts with home living with money management, d appropriate use of check sive buying.				
	C1 was open to sever Incorporated, and of ITP further indicated TACT (Transition Agreem which was a process of the community-based of adolescents and yow with functioning at the community due to a diagnosis) and case	atment Plan (ITP) indicated veral programs at People urrently lives at People II. The d she was also served by ge Community Treatment) program that provides nental health services to ung adults who are struggling nome, in school, or in the a serious mental health e management. The ITP ms currently share the same				

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	24G435					C 14/2022	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 206	programs:  Employment: C1 struggles to havin the community areas a way to explore  Goal- TACT provided discuss the barrier at lintervention: TACT coach her on suitable employment that shiplay conflicts that multiple independent Living C1 would like to lead living skills of budge eating and self-care Goal- C1 would like independent living splanning, healthy eat Description- C1 will practice skills of budgets.	indicated the following  e more independence, safely and employment was identified her independence.  ers will meet with C1 weekly to and maintaining employment will work to identify barrier, ble skills, support in looking for a can manage, and finally role hay arise.  Skills:  ern and practice independent eting, meal planning, healthy existed to learn and practice skills of budgeting, meal	W 20				
	Social Function: C1 trusts people too trouble	o quickly and has gotten in					

		TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  PEOPLE II  STREET ADDRESS, CITY, STATE, ZIP CODE 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)  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	24G435			B. WING _					
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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					1380 WEST MINNEHAHA PARKWAY	•			
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	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETION DATE		
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	W 206	Goal- C1 wants to I people and make n Intervention: Meet v safe skills for makin management will m progress towards g needed.  Review of C1's recestated goals were in monitored for changeregression.  During interview on supervisor (PS) staprograms written for documenting any d except a progress or reviewed. The PS moving forward.  During interview on president of operating with her Tathey are working or C1. The VPO state with required freque would have if the pibe in a progress not Facility Policy Peop 10/16, indicated "It provide each individe treatment according regulations. Active consistent implements	learn to be more social with more friends.  with TACT workers to developing new friendships. Case neet with C1 monthly to review loal and discuss topics as  ords lacked evidence above implemented, documented or ges based on success or  a 3/14/22, at 2:00 p.m. program atted Peoples II does not have or C1 and they are not lata towards meeting her goals note and this is not being stated they will be starting this and they are not with lateral towards meeting her goals note and this is not being stated they will be starting this and a making measurable goals for lead the goals are not written lencies and the only data they rograms were being run would on the from the staff.  The II Active Treatment revised is the policy of People II to dual with continuous active get of federal and state treatment includes aggressive, entation of a program to	W 20	6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		24G435	B. WING		C <b>03/14/2022</b>	
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/1	4/2022
DE 0 DI E			1	380 WEST MINNEHAHA PARKWAY		
PEOPLE	II		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 206	Continued From pa	ge 13	W 206			
W 252	and skills necessar level of independen		W 252	Data Collection data sheets will be created based on the current treatm goals established. Staff will be trained	ent	4/15/22
	specified in client in	omplishment of the criteria dividual program plan documented in measurable		on the Data Collection data sheets a the staff meeting. Program Leaders will ensure that employee training is complete and that completion is properly documented. Program Supervisor will monitor the Data	at hip	
	Based on interview facility failed to ensu programs and colle frequency identified Plan (ITP) so client and revised based of	s not met as evidenced by: y and document review, the ure that staff implemented cted data according to the in the Integrated Treatment programs could be monitored on client progress or 3 clients (C3) reviewed for		Collection data sheets on a bi-week basis to ensure data collection is be tracked for all established goals. Qll will conduct quality assurance audit a quarterly basis to ensure fulfillmer goals and that related data is being collected so client programs could be monitored and revised based on client progress or regression.	eing DP s on at of	
	Findings include:			Owner: Program Supervisor		
	(CFA) dated 11/20/2 Asperger's (signification and non- bipolar disorder and indicated C3 does r	re Functional Assessment 21, indicated C3 had ant difficulties in social verbal communication), danxiety. The CFA further not like to brush his teeth and e living skills but may refuse.				
	Review of C3's ITP	indicated the following:				
	Goal #1 I would like healthy get cavities and hav	teeth and gums so that I don't re bad breath.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		240.55	B. WING		-	С	
	24G435				_	03/	14/2022
NAME OF PROVIDER OR SUPPLIER  PEOPLE II				STREET ADDRESS, CITY, STA 1380 WEST MINNEHAHA F MINNEAPOLIS, MN 554	PARKWAY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIV CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 252	Continued From pa	ge 14	W 2	52			
	Objective: C3 will be	rush 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.						
	following codes 0- coutcome, 2- compleassistance. 3- comp	tracking sheet using the declined, 1- completed eted outcome with verbal pleted outcome with physical tcome not completed.					
	health support spec document once dail if he brushed his te- codes. The MHSS- they were supposed	14/22, at 2:30 p.m. mental sialist (MHSS)-B stated they ly on electronic medical record eth and are not using the -B stated he was not aware d to be documenting twice stated C3 almost always					
	Goal #2						
	I would like to get b clean and put away	etter at keeping my clothes					
	Objective: C3 will w bedding weekly.	ash all of his laundry including					
	when C3 washes a	will be considered achieved nd dries his clothes at least each month for 3 consecutive					
		hat day on C3's goal tracking owing codes 0- declined X-					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24G435	B. WING_		03/1	; 4/2022
NAME OF PROVIDER OR SUPPLIER  PEOPLE II			STREET ADDRESS, CITY, STATE, ZIP CODE  1380 WEST MINNEHAHA PARKWAY  MINNEAPOLIS, MN 55419			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W 252	completed.	ge 15 14/22, at 2:35 p.m. MHSS-C	W 2	52		
W 455	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.  INFECTION CONTROL CFR(s): 483.470(I)(1)					or on
			W 45	Program Manager and Supervisor corrected this violation and staff were trained. Staff were also sent a remir	e re-	
	prevention, control, and communicable This STANDARD is Based on observat review, the facility fa wore appropriate per (PPE) to include ey with the Center of E	s not met as evidenced by: ion, interview, and document ailed to ensure employees ersonal protective equipment e protection in accordance Disease Control (CDC) the potential to affect all five		email. Program Manager and Supervisor will conduct and document random onsite staff observations to ensure Infection Control standards are successfully met.  Owner: Program Supervisor.		
	Findings include:					
	program supervisor nurse (RN) were ob	ion 3/08/22, at 2:00 p.m. the (PS) and the float registered oserved in the home with a no PPE eye protection on. In				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G435	B. WING			C	
NAME OF F	PROVIDER OR SUPPLIER	240433	B: Willia _	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	14/2022	
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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
W 455	addition, mental hea (MHSS)-B was obsoloth mask and not MHSS-B was subset assisting the clients them thorough the I During an observation of the surgical mask and mask and mask are cloth facial mask are interview, the PS stometries was represented by the mask of the subset of the s	alth support specialist erved to be wearing a black PPE eye protection on. equently observed to be with snacks and talking with home.  ion and interview 3/09/22, at as observed to be wearing a no eye PPE on. In addition, rved to be wearing a black of no eye PPE. During ated they have been laxed on E and really have not been onths and informed MHSS-B mask.  3/09/22 at 9:45 a.m. the ring his orientation in January informed he needed to wear ot been wearing them since ditionally, MHSS-B stated her of the staff wearing eye PPE.	W 45	5			