



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed August 10, 2020

Administrator
Phoenix at English
1336 East County Road E
Vadnais Heights, MN 55110

Re: Project Number HG492002C
Event ID: ODEE11

Dear Administrator:

On July 22, 2020, an abbreviated survey was completed at your facility to conduct a complaint investigation. Phoenix at English is in full compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).

At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements promulgated under Minnesota Statutes Section 144.653, Minnesota Statutes Section 144.057 and Minnesota Statutes Section 144A.70 through 144A.74.

Attached is the State Form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State survey findings 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.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads "Amy Johnson".

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Enclosure



Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed August 10, 2020

Administrator
Phoenix at English
1336 East County Road E
Vadnais Heights, MN 55110

RE: Project Number HG492002C
Event ID: ODEE11

Dear Administrator:

On July 22, 2020, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.

HG492002C was found to be substantiated with no deficiencies cited.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

Enclosed is your copy of the Federal Forms CMS-2567.

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,

A handwritten signature in cursive script that reads 'Amy Johnson'.

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/22/2020
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NAME OF PROVIDER OR SUPPLIER PHOENIX AT ENGLISH	STREET ADDRESS, CITY, STATE, ZIP CODE 1336 EAST COUNTY ROAD E VADNAIS HEIGHTS, MN 55110
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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) COMPLETE DATE
5 000	<p>Initial Comments</p> <p>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.</p> <p>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.</p> <p>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 7/22/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Phoenix at English is in full compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).</p>	5 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G492	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/22/2020
NAME OF PROVIDER OR SUPPLIER PHOENIX AT ENGLISH			STREET ADDRESS, CITY, STATE, ZIP CODE 1336 EAST COUNTY ROAD E VADNAIS HEIGHTS, MN 55110		
(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	<p>INITIAL COMMENTS</p> <p>On 7/22/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.</p> <p>HG492002C was found to be SUBSTANTIATED with no deficiencies cited.</p>	W 000			
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.