DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

November 22, 2021

Administrator
Phoenix At Janet Court
1769 Janet Court
Arden Hills, MN 55112

RE: Event ID: N07611

Dear Administrator:

On November 1, 2021 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. At the time of the survey, the survey team noted one or more deficiencies.

Federal certification deficiencies are delineated on the electonically delivered 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). Ordinarily, a provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.

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 correction will be completed

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

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

POC Received- 11-23-21
POC Approved- 12-7-21
Liz Silkey

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

PRINTED: 11/22/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G515	A. BUILDING _____ B. WING _____	C 11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX AT JANET COURT	1769 JANET COURT ARDEN HILLS, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On 11/1/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following complaints were found to be SUBSTANTIATED: HG515008C (MN77861) with no deficiency cited. HG515009C (MN76107) with a deficiency cited at W339. The following complaint was found to be UNSUBSTANTIATED: HG515007C (MN77888). However, as a result of the investigation, a deficiency was cited at W154. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	W 000	W 154 339 This Plan of Correction (POC) is a written credible assertion of substantial compliance with the federal requirements and Conditions of Participation for ICFs/IDD. Nothing set forth in this POC or any communication is to be or should be construed as an admission by Phoenix at Janet Court, or any employees, representative or agent of Phoenix at Janet Court, of the validity of accuracy of any of the deficiencies cited by the Minnesota Department of Health relative to the survey, certification and enforcement effort at issue. Further, please note that any and all documents transmitted or otherwise provided by Phoenix at Janet Court in relation to this POC, as well as any and all other communications in writing or otherwise by or on behalf of Phoenix at Janet Court are and shall be construed to be WITHOUT PREJUDICE to the rights, remedies, claims, defenses of Phoenix at Janet Court, at law and / or equity, none of which are waived and all of which are reserved and retained by, for and on behalf of Phoenix at Janet Court.	
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of physical abuse for 1 of 1 client (C1) reviewed for allegations of abuse. Findings include: C1's emergency data form printed 11/1/21, indicated diagnoses of moderate intellectual	W 154	**W Tag 154** 1. Corrective action for those clients affected will be accomplished as follows: The Facility will ensure that all allegations of physical abuse are thoroughly investigated for 1 of 1 client. 2. Identification of other clients with the potential to be affected by the deficient practice will occur as follows: All individuals have an IAPP in place to best support their needs. 3. The facility has or will put the following measures into place to prevent a recurrence of the	12/22/21 12/22/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert M Scott — TITLE: President & CEO — (X6) DATE: 11/23/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 154	Continued From page 1 disabilities and myopathy (muscle weakness). C1's individual abuse prevention plan (IAPP) dated 4/20/20, identified C1 was vulnerable to physical abuse. The IAPP indicated C1 would not have been able to prevent physical harm or defend himself. Additionally, C1 required assistance with navigation in his environment. Lastly, C1 might not verbally express and/or report abuse. Review of C1's general event report (GER) form indicated on 10/20/21, the facility received an email from C1's day program. The email identified C1 rode on the bus, arrived at his day program and the day program noticed he was crying. C1 reported to the day program staff that a "tall man" hit him. Review of the facility's internal review form dated 10/20/21, indicated the assistant program director (APD) met with C1 and his mother after becoming aware of the allegations and completed an interview. C1 identified direct support personnel (DSP)-A in a photo in regards to the allegations, however C1 also said the name "Maurice" which was not DSP-A's name. APD then interviewed the day program staff whom reported no one by the name of Maurice works at the location. APD interviewed DSP-A who denied any allegations. Additionally, DSP-A had not worked with C1 in the past week. The facility filed a report with the Minnesota Adult Abuse Reporting Center (MAARC). The internal review form lacked any interviews with other staff, including the staff that physically worked with C1 the morning the allegation was said to have occurred. The internal review form lacked any interviews with other clients of the home.	W 154	W154 cont deficient practice: All staff will be retrained on all individuals IAPP. 4. The facility will monitor its performance to make sure solutions are sustained as follows: The Program Director is responsible for monitoring the facility's performance and for making sure the solutions identified above are sustained. This will occur through delegation of daily monitoring of the Program by the Program Manager and Lead Direct Support Staff, through audits of the facility's polices, review of medical records documentation, and staff training. The Program Director will also regularly audit the facility's handling of allegations of abuse and neglect to ensure that the appropriate procedures are followed and that solutions are sustained. 5. Corrective action will be completed by the following date: All corrections noted above were implemented by the facility by: 12/22/2021	12/22/21

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W 154	Continued From page 2 When interviewed on 11/1/21, at 9:45 a.m. family member (FM)-A stated she was aware of the allegation C1 had made. FM-A stated the facility told her the results of their investigation were inconclusive. FM-A stated she thought C1 was safe at the facility but wondered what would happen if the allegation occurred again. When interviewed on 11/1/21, at 10:38 a.m. C1 stated he liked the staff and had no concerns about his care. When interviewed on 11/1/21, at 11:59 a.m. the day program supervisor (PS)-A stated C1 had limited communication. Regarding the above incident, C1 arrived at the day program via his bus on 10/20/21, and reported a tall man hit him. C1 reported he had been hit at his house and not on the bus. C1 was seen by the day program behavior specialist and there were no further concerns. PS-A stated C1 had no history of making abuse allegations while at the day program. When interviewed on 11/1/21, at 12:20 p.m. the APD stated during an investigation of abuse allegations other staff, visitors and residents would be interviewed. APD stated they had not interviewed DSP-C or DSP-E who had both worked with C1 the morning the allegation was said to have occurred. APD stated she had not conducted further interviews because C1 had only pointed to DSP-A in the photo. When interviewed on 11/1/21, at 1:03 p.m. DSP-E stated he probably got C1 ready for his day program on 10/20/21. DSP-E stated no one had asked him about the care provided that day and	W 154		

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W 154	Continued From page 3 he was not aware of any concerns. Facility policy Maltreatment of Vulnerable Adults Reporting, dated 12/31/10, indicated reports to MAARC would initiate an investigation. The investigation would consist of an interview to include all (applicable) parties involved: the reporter, suspected person, venue, emergency services, etc. If there is a reason to believe allegations of abuse have occurred when the perpetrator is not known, a buddy system (double staff model) of care would be implemented immediately during the course of the investigation.	W 154	**W Tag_339** 1. Corrective action for those clients affected will be accomplished as follows: The Facility will ensure that all transfer assessments are done for all clients. 2. <u>Identification of other clients with the potential to be affected by the deficient practice will occur as follows:</u> All individuals have a transfer assessment in place to best support their safety and transfers. 3. The facility has or will put the following measures into place to prevent a recurrence of the deficient practice: All staff will be retrained on all individuals transfer assessments. Program Manager will be retrained on how to update transfer assessments when changes are needed. 4. The facility will monitor its performance to make sure solutions are sustained as follows: The Program Director is responsible for monitoring the facility's performance and for making sure the solutions identified above are sustained. This will occur through delegation of daily monitoring of the Program by the Program Manager and Lead Direct Support Staff, through audits of the facility's polices, review of medical	12/22/21
W 339	NURSING SERVICES CFR(s): 483.460(c)(4) Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to use the proper transferring devices in order to ensure safe transfers for 2 of 3 clients (C2, C3) reviewed for activities of daily living (ADLs). Findings include: C2's emergency data form (EDF) printed 11/1/21, indicated an admission date of 3/30/20. The EDF indicated C2 had diagnoses of moderate intellectual disabilities and myopathy (muscle weakness). The EDF indicated C2 used a wheelchair for mobility, would also walk on his knees but was unstable, had weakness on one side of his body and a mechanical transfer was to be used.	W 339		12/22/21

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W 339	Continued From page 4 C2's individual services plan (ISP) ADL program lacked details for completing transfers. During an observation on 11/1/21, at 10:02 a.m. C2 asked direct support professional (DSP)-C to help him to the bathroom. DSP-C pushed C2 in his wheelchair to the toilet and locked the brakes. DSP-C unbuckled C2's seat belt. DSP-C grabbed onto C2 ' s pant waist band and lifted him up and onto the toilet. C2's feet did not touch the ground and C2 had not participated in the transfer up to this point. DSP-C asked C2 to hold the grab bars on both sides of the toilet and lift up his pelvis, it took several attempts, but DSP-C was able to get C2's brief and pants pulled down. C2 used the toilet and DSP-C helped client clean up. DSP-C again asked C2 to lift up his pelvis and she pulled up his pants and brief. DSP-C then grabbed onto C2's pant waist band and lifted him up and onto the toilet. Again, C2's feet did not touch the ground and he had not participated in the transfer. C2's pants were pulled up high above his waist so DSP-C asked him to lift his pelvis up again and she pulled his pants and brief down. C3's EDF printed 11/1/21, indicated an admission date of 3/9/21. The EDF indicated C3 had diagnoses of moderate intellectual disability and schizophrenia. The EDF indicated C3 relied on mechanical lift transfer, or she could stand with two staff to transfer. C3's individual services plan (ISP) ADL program lacked details for completing transfers. During an observation on 11/1/21, at 10:38 a.m. C3 told DSP-C that she needed to be changed.	W 339	W339 Cont records documentation, and staff training. The Program Director will also regularly audit the facility's handling of allegations of abuse and neglect to ensure that the appropriate procedures are followed and that solutions are sustained. 5. Corrective action will be completed by the following date: All corrections noted above were implemented by the facility by: _____12/22/2021_____	12/22/21

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W 339	Continued From page 5 DSP-C pushed C3 in her wheelchair to her bedside and locked the brakes. C3 held onto the bed side rail, DSP-C grabbed onto C3's pants waist band and lifted her up to a partially standing position and pivot transferred C3 into her bed to a sitting position. C3 appeared to bear some weight but her knees were buckled. DSP-C then moved C3's legs up onto the bed, changed her brief and pulled up her pants. DSP-C assisted C3 back to a sitting position. C3 grabbed onto her wheelchair arm rests and DSP-C put her hands in C3's armpits and lifted her by the shoulders to complete a pivot transfer into the wheelchair. C3 appeared to bear some weight but her knees were buckled. During an interview 11/1/21, at 10:53 a.m. DSP-C stated there were no clients that required a mechanical lift for transfers. DSP-C also stated her normal process was to transfer residents using the waist band of their pants. DSP-C stated she was not sure if transfer belts were required. During an interview on 11/1/21, at 12:20 p.m. the assistant program director (APD) reviewed C2 and C3's EDF's. APD stated transfer belts should always be used during a transfer with assistance when the client can bear weight. APD stated she was unsure how C2 was supposed to transfer, he did a lot independently on his knees. APD stated she was unsure how he was supposed to transfer out of his wheelchair onto the toilet. APD stated if the emergency data form indicated a mechanical lift then that is what should have been used for the transfer and it was not. APD stated if C3 had not transferred with the mechanical lift, then two staff should have been present per the EDF, and they were not. APD reviewed facility files for any	W 339		

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W 339	Continued From page 6 incident reports and there were no injuries or falls for C2 or C3 in the past three months. During interview on 11/1/21, at 12:55 p.m. DSP-B stated staff are always supposed to use transfer belts to transfer clients. DSP-B went to the laundry room and located a transfer belt. During interview on 11/1/21, at 1:31 p.m. the program manager (PM) stated it was not acceptable to transfer clients using their pants waist band or lifting from under their shoulders as there was a potential for injury for staff and clients. Additionally, transfer belts should be used at all times. PM stated the nurse would have done training and a transfer assessment when the clients were first admitted, however they could not locate that training at this time. During interview 11/1/21, at 2:24 p.m. the director of nursing (DON) stated the C2 and C3 should have transfer assessments on file and they did not. Additionally, clients should not be transferred by staff pulling on their clothing or body parts, and a transfer belt should be used. The DON stated C2 and C3's transferring process needed clarification. Facility policy Transfers, dated 5/15, indicated members of the interdisciplinary team would select the most appropriate equipment and transfer option. All staff would review transfer guidelines and bed mobility recommendations quarterly and be retrained on lifting and bed mobility procedures on an annual basis or as needed.	W 339		

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	23588	A. BUILDING: _____ B. WING _____	C 11/01/2021

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 11/1/21, a complaint investigation was conducted. Your facility was found to be in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaints were found to be SUBSTANTIATED with no licensing orders issued: HG515008C (MN77861) HG515009C (MN76107).	5 000		

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5 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: HG515007C (MN77888).	5 000		

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX AT JANET COURT	1769 JANET COURT ARDEN HILLS, MN 55112

(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 154	Continued From page 2 When interviewed on 11/1/21, at 9:45 a.m. family member (FM)-A stated she was aware of the allegation C1 had made. FM-A stated the facility told her the results of their investigation were inconclusive. FM-A stated she thought C1 was safe at the facility but wondered what would happen if the allegation occurred again. When interviewed on 11/1/21, at 10:38 a.m. C1 stated he liked the staff and had no concerns about his care. When interviewed on 11/1/21, at 11:59 a.m. the day program supervisor (PS)-A stated C1 had limited communication. Regarding the above incident, C1 arrived at the day program via his bus on 10/20/21, and reported a tall man hit him. C1 reported he had been hit at his house and not on the bus. C1 was seen by the day program behavior specialist and there were no further concerns. PS-A stated C1 had no history of making abuse allegations while at the day program. When interviewed on 11/1/21, at 12:20 p.m. the APD stated during an investigation of abuse allegations other staff, visitors and residents would be interviewed. APD stated they had not interviewed DSP-C or DSP-E who had both worked with C1 the morning the allegation was said to have occurred. APD stated she had not conducted further interviews because C1 had only pointed to DSP-A in the photo. When interviewed on 11/1/21, at 1:03 p.m. DSP-E stated he probably got C1 ready for his day program on 10/20/21. DSP-E stated no one had asked him about the care provided that day and	W 154		

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W 154	Continued From page 3 he was not aware of any concerns. Facility policy Maltreatment of Vulnerable Adults Reporting, dated 12/31/10, indicated reports to MAARC would initiate an investigation. The investigation would consist of an interview to include all (applicable) parties involved: the reporter, suspected person, venue, emergency services, etc. If there is a reason to believe allegations of abuse have occurred when the perpetrator is not known, a buddy system (double staff model) of care would be implemented immediately during the course of the investigation.	W 154		
W 339	NURSING SERVICES CFR(s): 483.460(c)(4) Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to use the proper transferring devices in order to ensure safe transfers for 2 of 3 clients (C2, C3) reviewed for activities of daily living (ADLs). Findings include: C2's emergency data form (EDF) printed 11/1/21, indicated an admission date of 3/30/20. The EDF indicated C2 had diagnoses of moderate intellectual disabilities and myopathy (muscle weakness). The EDF indicated C2 used a wheelchair for mobility, would also walk on his knees but was unstable, had weakness on one side of his body and a mechanical transfer was to be used.	W 339		

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W 339	Continued From page 4 C2's individual services plan (ISP) ADL program lacked details for completing transfers. During an observation on 11/1/21, at 10:02 a.m. C2 asked direct support professional (DSP)-C to help him to the bathroom. DSP-C pushed C2 in his wheelchair to the toilet and locked the brakes. DSP-C unbuckled C2's seat belt. DSP-C grabbed onto C2 ' s pant waist band and lifted him up and onto the toilet. C2's feet did not touch the ground and C2 had not participated in the transfer up to this point. DSP-C asked C2 to hold the grab bars on both sides of the toilet and lift up his pelvis, it took several attempts, but DSP-C was able to get C2's brief and pants pulled down. C2 used the toilet and DSP-C helped client clean up. DSP-C again asked C2 to lift up his pelvis and she pulled up his pants and brief. DSP-C then grabbed onto C2's pant waist band and lifted him up and onto the toilet. Again, C2's feet did not touch the ground and he had not participated in the transfer. C2's pants were pulled up high above his waist so DSP-C asked him to lift his pelvis up again and she pulled his pants and brief down. C3's EDF printed 11/1/21, indicated an admission date of 3/9/21. The EDF indicated C3 had diagnoses of moderate intellectual disability and schizophrenia. The EDF indicated C3 relied on mechanical lift transfer, or she could stand with two staff to transfer. C3's individual services plan (ISP) ADL program lacked details for completing transfers. During an observation on 11/1/21, at 10:38 a.m. C3 told DSP-C that she needed to be changed.	W 339		

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W 339	Continued From page 5	W 339		

DSP-C pushed C3 in her wheelchair to her bedside and locked the brakes. C3 held onto the bed side rail, DSP-C grabbed onto C3's pants waist band and lifted her up to a partially standing position and pivot transferred C3 into her bed to a sitting position. C3 appeared to bear some weight but her knees were buckled. DSP-C then moved C3's legs up onto the bed, changed her brief and pulled up her pants. DSP-C assisted C3 back to a sitting position. C3 grabbed onto her wheelchair arm rests and DSP-C put her hands in C3's armpits and lifted her by the shoulders to complete a pivot transfer into the wheelchair. C3 appeared to bear some weight but her knees were buckled.

During an interview 11/1/21, at 10:53 a.m. DSP-C stated there were no clients that required a mechanical lift for transfers. DSP-C also stated her normal process was to transfer residents using the waist band of their pants. DSP-C stated she was not sure if transfer belts were required.

During an interview on 11/1/21, at 12:20 p.m. the assistant program director (APD) reviewed C2 and C3's EDF's. APD stated transfer belts should always be used during a transfer with assistance when the client can bear weight. APD stated she was unsure how C2 was supposed to transfer, he did a lot independently on his knees. APD stated she was unsure how he was supposed to transfer out of his wheelchair onto the toilet. APD stated if the emergency data form indicated a mechanical lift then that is what should have been used for the transfer and it was not. APD stated if C3 had not transferred with the mechanical lift, then two staff should have been present per the EDF, and they were not. APD reviewed facility files for any

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W 339	Continued From page 6	W 339		

incident reports and there were no injuries or falls for C2 or C3 in the past three months.

During interview on 11/1/21, at 12:55 p.m. DSP-B stated staff are always supposed to use transfer belts to transfer clients. DSP-B went to the laundry room and located a transfer belt.

During interview on 11/1/21, at 1:31 p.m. the program manager (PM) stated it was not acceptable to transfer clients using their pants waist band or lifting from under their shoulders as there was a potential for injury for staff and clients. Additionally, transfer belts should be used at all times. PM stated the nurse would have done training and a transfer assessment when the clients were first admitted, however they could not locate that training at this time.

During interview 11/1/21, at 2:24 p.m. the director of nursing (DON) stated the C2 and C3 should have transfer assessments on file and they did not. Additionally, clients should not be transferred by staff pulling on their clothing or body parts, and a transfer belt should be used. The DON stated C2 and C3's transferring process needed clarification.

Facility policy Transfers, dated 5/15, indicated members of the interdisciplinary team would select the most appropriate equipment and transfer option. All staff would review transfer guidelines and bed mobility recommendations quarterly and be retrained on lifting and bed mobility procedures on an annual basis or as needed.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 22, 2021

Administrator
Phoenix At Janet Court
1769 Janet Court
Arden Hills, MN 55112

Re: Event ID: NO7611

Dear Administrator:

The above facility survey was completed on November 1, 2021 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

Sincerely,

Kim Tyson

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

Minnesota Department of Health

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	23588	A. BUILDING: _____ B. WING _____	C 11/01/2021

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 11/1/21, a complaint investigation was conducted. Your facility was found to be in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaints were found to be SUBSTANTIATED with no licensing orders issued: HG515008C (MN77861) HG515009C (MN76107).	5 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marlene M Scott — TITLE: President / CEO — (X6) DATE: 11/23/21

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5 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: HG515007C (MN77888).	5 000		