DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

March 24, 2022

Administrator
Homeward Bound Brooklyn Park
7839 Brooklyn Blvd
Brooklyn Park, MN 55445

RE: Event ID: YKSR11

Dear Administrator:

On March 11, 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 7, 2022 for W158 and on March 11, 2022 for W318.

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):

W158 42 CFR § 483.430 – Facility Staffing
W318 42 CFR § 483.460 - Health Care Services

Federal certification deficiencies are delineated on the enclosed form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC).

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correctionk will be completed.

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

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:

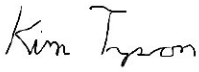
Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 5, 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
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	24G286		C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWARD BOUND BROOKLYN PARK	7839 BROOKLYN BLVD BROOKLYN PARK, MN 55445

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W 000	INITIAL COMMENTS On 2/28/22 through 3/11/22, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following complaints were found to be SUBSTANTIATED: HG286054C (MN81208) with deficiency cited at W331. HG286056C (MN81132) with a deficiency cited at W331. HG286055C (MN81127 & MN81332) with a deficiency cited at W331. The Condition of Participation: Facility Staffing 42 CFR 483.430 was found not to be met. An Immediate Jeopardy (IJ) was identified at W508 on 3/03/22, at 3:13 p.m. The IJ began on 3/1/22, when the facility staff were observed to not be properly utilizing personal protective equipment (PPE) eye wear while providing client cares, nor maintaining a minimum of six-foot distance when not wearing PPE properly as recommended by the Centers for Disease Control (CDC) to reduce the spread of COVID infection. The facility also failed to identify that five employees who remained on the schedule were not fully vaccinated or had approved exemptions. The program administrator of quality assurance (PAQA) was informed of the IJ on 3/3/22, at 3:13 p.m. The immediate jeopardy was removed on 3/7/22, at 11:00 a.m. when the facility's approved removal plan was	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.

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W 000	Continued From page 1 verified onsite by the State agency. The Condition of Participation: Health Care Services 42 CFR 483.460 was found not to be met. An Immediate Jeopardy (IJ) was identified at W331 on 3/03/22, at 5:11 p.m. The IJ began on 2/17/22, when the facility failed to complete a fall assessment and implement new interventions to prevent future falls for C1 who had multiple falls with injuries. The Program Administrator of Quality Assurance (PAQA) was notified of the IJ on 3/3/22, at 5:11 p.m. The immediate jeopardy was removed on 3/11/22, at 12:27 p.m. when the facility's approved removal plan was verified onsite by the state agency. 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 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the The Condition of Participation: Facility Staffing 42 CFR 483.430 was not met. Findings include: See W508: Facility failed to implement infection control practices related to the use of personal protective equipment in order to reduce the spread of COVID 19. Additionally, the facility failed to develop and implement Covid Health	W 158		

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W 158	Continued From page 2 Care Staff Vaccination policies and procedures and failed to ensure 100% of staff were either fully vaccinated or had approved exemptions as evidenced by 5 out of 83 employees who remained on the schedule and were unvaccinated and had not applied for an exemption. This resulted in an immediate jeopardy (IJ).	W 158		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to have a qualified intellectual disability professional (QIDP) who provided consistent oversight of each client's needs and individual program plans to ensure the clients received the care and services needed in order to maintain their highest level of functioning for 3 of 3 clients (C1, C2 and C3) reviewed for treatment programs. This had the potential to affect all 25 clients residing in the facility. Findings include: During an interview on 3/8/22, at 9:30 a.m. the operations administrator (OA) stated being new to the role, and that the previous OA had resigned without notice. The OA stated the supervisor at the Woodland's location last day was 12/16/21, and the supervisor at the Fernbrook's location last day was 11/30/21. The OA was unable to find any information on C1, C2 or C3's programs for any updates going back to September 2021. During an interview on 3/11/22, at 10:00 a.m. the	W 159		

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W 159	Continued From page 3 program administrator of quality assurance (PAQA), stated the facility had a former operations administrator (OA) who was the QIDP for the facility and had quit about a month ago, without notice. The PAQA verified the former OA, who also served as the QIDP, was not making sure client programs were being reviewed for revisions or changes. The PAQA stated since the former OA had left, they have not had a QIDP in the building, and that the program supervisors for the Woodland and Fernbrook locations had resigned several months ago. The PAQA stated there was some data that the programs were being run, but no one was reviewing the data. The PAQA stated as of 3/4/22, they had a new who would be making sure all requirement would be met. During an interview on 3/11/22, at 10:30 a.m. the director of program operations stated she looked into the computer system and was not able to find any documentation of any updates for C1, C2 and C3's programs which should have been done by the program supervisor, OA, and QIDP. A policy was requested but not provided.	W 159		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.460 Health Care Services, was not met.	W 318		

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W 318	Continued From page 4 Findings include: See W331: Facility failed to ensure nursing services were implemented for physician orders, fall assessments, and new interventions to prevent future falls for 1 of 2 clients (C1) reviewed who had multiple falls with injuries. C1 was observed ambulating without 1:1 assistance and had not been reassessed after four falls, and had no new interventions to prevent falls. C1's fall injuries included injury to the mouth and re-opening of wounds. This resulted in an immediate jeopardy (IJ) situation for C1.	W 318		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nursing services were implemented for physician orders, fall assessments, and new interventions to prevent future falls for 1 of 2 clients (C1) reviewed who had multiple falls with injuries. C1 was observed ambulating without 1:1 assistance and had not been reassessed after four falls, and had no new interventions to prevent falls. C1's fall injuries included injury to the mouth and re-opening of wounds. This resulted in an immediate jeopardy (IJ) situation for C1. The IJ began on 2/17/22, when the facility failed to complete a fall assessment and implement new interventions to prevent future falls for C1 who had multiple falls with injuries. The program administrator of quality assurance (PAQA) was	W 331		

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W 331	Continued From page 5 notified of the IJ on 3/3/22, at 5:11 p.m. The immediate jeopardy was removed on 3/11/22, at 12:27 p.m. when the facility's approved removal plan was verified onsite by the state agency. Findings include: During observation on 2/28/22, at 2:00 p.m. C1 was observed walking around in Woodland apartment with his gait belt on and helmet, with a clear shield covering his mouth. C1 was walking independently with no staff assistance. During observation on 3/1/22, at 10:00 a.m. C1 was observed in Woodland apartment with his helmet and gait belt on walking independently throughout the apartment with no staff walking with him. During observation from 2/28/22, through 3/2/22, the EZ Way lift and nurse on a stick (vital sign machine) remained stored in the same place were C1 had tripped and fell. Also, there were six dresser drawers observed stacked up against the wall next to the EZ Way lift. C1's Face Sheet undated, indicated he had profound intellectual disability, cerebral palsy and legal blindness. C1's Coordinated Services Support Plan (CSSP) dated 10/13/21, indicated a diagnosis of autism and C1 would pace back and forth or wander around in the home. The CSSP indicated due to lack of sleep, C1 being legally blind, and his feet pointing inward, C1 was at extremely high risk for falls. The CSSP directs staff to walk with C1 holding his gait buckle to prevent falls.	W 331		

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W 331	Continued From page 6 C1's Physician Orders indicated on 1/6/22, 1:1 supervision required due to high risk of falls and impulsive behavior. In addition, C1's Physician Orders indicated a new helmet with face shield. C1's Health Needs Record (HNR) dated 2/08/22, indicated C1 was identified as a high fall risk and C1 had inverted lower extremities. The HNR indicated C1 was unable to walk independently, as he was a 1:1 for safety precautions. Review of C1's falls indicated the following: 2/17/22, Fall 8:00 a.m. C1 tripped on EZ Way (mechanical transferring device) and had his old helmet on, not the new one with shield. C1 sustained a scratch on right side of nose, with blood coming from his mouth. C1 was walking independently at time of fall. C1 sent to urgent care, no acute concerns. 2/19/22, Fall 12:00 p.m. witnessed. C1 had helmet on and gait belt. C1 was bleeding from old wound. First Aid was provided. 2/23/22, Fall at 9:45 a.m. C1 tripped and fell in living room. Unclear if C1 was ambulating independently. C1 was bleeding from old wound, pressure applied. First aid provided. 3/1/22, Fall at 3:40 p.m. staff observed C1 walking towards living room alone, and staff followed C1 at the time he fell. Review of all fall reports lacked evidence an internal review was completed to determine if CSSP was followed, if C1 was re-assessed post fall, or if fall interventions were implemented to prevent future falls.	W 331		

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W 331	Continued From page 7 During an interview 2/28/22, at 4:00 p.m. direct support staff (DSS)-A stated she was not aware C1's HNR indicated C1 was not supposed to walk independently and was supposed to be 1:1.. DSS-A stated, "It is impossible to walk with [C1] at all times, we just don't have enough staff." DSS-A stated with the fall where C1 tripped on the EZ Way, it was in the back of the apartment against the wall. DSS-A pointed at the EZ Way and stated, "it was right there, where it is now." DSS-A stated C1 tripped over the vital sign machine (nurse on a stick) while the nurse was taking another client's blood pressure. DSS-A pointed to the nurse on a stick, which was next to the cabinet, across from the kitchen table. During interview on 2/28/22, at 4:45 p.m. DSS-B stated she was not aware of C1's HNR indicating he required 1:1 and was not to ambulate independently. DSS-B stated the dresser drawers have been in the hall stacked against the wall for weeks because another client received a new dresser, and no one removed the old one. During interview on 3/1/22, at 11:35 a.m. nurse case manager NCM-A stated C1 ideally should have 1:1 to prevent falls and had a doctor's order but they cannot follow the order. NCM-A stated management was aware of the order and know they cannot follow the doctor order. NCM-A added they see C1 walking alone in the apartment all the time. NCM-A stated they don't have enough staff to provide 1:1 staff for C1. NCM-A stated the 5-Day investigations for C1's falls have not been done and that was the responsibility of the operating administrator, who walked off the job awhile back, so no one has been doing them. She stated they have no falls	W 331		

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W 331	Continued From page 8 committee to discuss the falls and the facility has a broken system. When asked if C1 was re-assessed after the falls, NCM-A stated no one looked at the incident report or reviewed concerns related to the falls such as medical or environmental factors. During interview on 3/1/22, at 2:00 p.m. the PAQA stated the operations administrator used to complete the internal reviews after a client falls within five days of the incident. The PAQA stated the operations administrator had quit, without notice, one month ago. PAQA stated staff have found some of the incident reports on staff members desks, not filled out, and should have been completed. Homeward Bound Policy and Procedure on Reviewing Incidents and Emergencies, dated 10/15, indicated the following: The internal review will be completed using the Internal Review form and will include an evaluation of whether: 1. Related policies and procedures were followed. 2. The policies and procedures were adequate. 3. If there is need for additional staffing. 4. If the reported event is similar to past events with the individuals or services involved. In addition, the policy indicated if there is a need for corrective action by the license holder to protect the health and safety of the individuals served, a corrective action plan will be designed to correct current lapses and prevent future lapses in performance by HBI staff if any. The immediate jeopardy that began on 2/17/22, was removed on 3/11/22, at 12:27 p.m. when C1 was re-assessed for falls and interventions were put in place, along with staff training and physical environment checks to ensure C1's safety. In	W 331		

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W 331	Continued From page 9 addition, there was competency training and oversight completed by the staff.	W 331		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the	W 508		

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W 508	Continued From page 10 facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility	W 508		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 508	Continued From page 11 has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	24G286		C 03/11/2022

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W 508	Continued From page 12 paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement infection control practices related to the use of personal protective equipment in order to reduce the spread of COVID 19. Additionally, the facility failed to develop and implement Covid Health Care Staff Vaccination policies and procedures and failed to ensure 100% of staff were either fully vaccinated or had approved exemptions as evidenced by 5 out of 83 employees who remained on the schedule and were unvaccinated and had not applied for an exemption. This resulted in an immediate jeopardy (IJ). The IJ began on 3/1/22, when the facility staff were observed to not be properly utilizing personal protective equipment (PPE) eye wear while providing client cares, nor maintaining a minimum of six-foot distance when not wearing PPE properly as recommended by the Centers for Disease Control (CDC) to reduce the spread of COVID infection. The facility also failed to identify that five employees who remained on the schedule were not fully vaccinated or had approved exemptions. The program administrator of quality assurance (PAQA) was informed of the IJ on 3/3/22, at 3:13 p.m. The immediate jeopardy was removed on 3/7/22, at 11:00 a.m. when the facility's approved removal plan was verified onsite by the State agency.	W 508		

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W 508	Continued From page 13 Findings include: During observation 3/1/22, at 9:00 a.m. direct support staff (DSS)-A was observed conversing with C3 and C4 who were both seated in recliners. DSS-A was noted to be wearing eye protection which was pulled up and resting on top of DSS-A's head. DSS-A proceeded to walk with C3 throughout the apartment and within six feet of each other for more than 15 minutes. While walking, C3 began to cough at which time DSS-A, who was standing next to C3, offered C3 water to drink. During this observation, DSS-B was observed assisting other clients, standing within six feet of each, with a face shield pulled up from the face and resting on top of her head. DSS-B remained within six of the clients for greater than 15 minutes. During observation on 3/1/22, at 9:15 a.m. staff were observed walking near and around clients in the client care area, without eye protection in place. Review of the facility Staff Matrix dated 2/28/22, indicated 83 total facility employees. The Matrix revealed five of the 83 employees had not been vaccinated and did not have an exemption or delay noted. On 3/2/22, the facility's staff vaccination rate standard was 93%. During interview on 3/2/22, at 9:30 a.m. employee (E)-A verified she had not received the COVID vaccination and had never been directed to or approached by the facility to obtain an exemption. E-A stated she was not aware of any additional	W 508		

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W 508	Continued From page 14 PPE that she should be wearing, or additional policies/procedures related to PPE that she was to follow. E-A added that she goes on break with all the other employees and when doing so, is within six feet of each other. The facility COVID Health Care Staff Vaccination policy lacked the following required components: -a process for ensuring the implementation of additional precautions intended to mitigate the transmission and spread of COVID-19 for all staff who were not fully vaccinated. -a process for tracking and securely documenting the COVID-19 vaccination status of all staff. -a process for tracking booster vaccination. -a contingency plan for staff who are not fully vaccinated for COVID-19. During an interview on 3/1/22, at 2:00 p.m. the director of nursing (DON) stated the director of human resources had written the policy which had been reviewed by an attorney and approved by the facility department heads therefore she had thought the policy contained all the required components. During an interview on 3/1/22, at 2:50 p.m. the DON stated the staff that are unvaccinated were required to wear a face mask and eye goggles which is no different than what the vaccinated staff are required to wear. The DON stated they had no additional infection control policies/procedures in place for unvaccinated staff because that would cause those individual to be identifiable, which was not right. During an interview 3/1/22, at 3:20 p.m. the PAQA and DON both stated the staff should always have eye protection on when in care areas, as	W 508		

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W 508	Continued From page 15 directed by facility policy The immediate jeopardy that began on 3/1/22, was removed 3/7/22, at 11:00 a.m. when the facility COVID Health Care Staff Vaccination policy was updated with the required components, additional precautions and assurance measures were put in place to mitigate COVID-19 transmission, staff with approved vaccination exemptions would take weekly COVID-19 antigen testing, and training on use of PPE provided to all staff.	W 508		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	01273		C 03/11/2022

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. A licensing review was conducted at your facility from 2/28/22 through 3/11/22. This survey was initiated as a result of the Immediate Jeopardy findings from abbreviated survey exited 3/11/22. Your facility was found not 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:	5 000		

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

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5 000	Continued From page 1 HG286054C (MN81208) with an order cited at 0380. HG286056C (MN81132) with an order cited at 0380. HG286055C (MN81127 & MN81332) with an order cited at 0380. When corrections are completed, please sign and date, make a copy of these orders and electronically return to: email Susie Haben at susie.haben@state.mn.us	5 000		
5 380	MN Rule 4665.3300 PURPOSE OF HEALTH SERVICES. Health services shall be utilized to maintain an optimal general level of health and to maximize function, prevent disability, and promote optimal development of each resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nursing services were implemented for physician orders, fall assessments, and new interventions to prevent future falls for 1 of 2 clients (C1) reviewed who had multiple falls with injuries. C1 was observed ambulating without 1:1 assistance and had not been reassessed after four falls, and had no new interventions to prevent falls. C1's fall injuries included injury to the mouth and reopening of wounds. Findings include:	5 380		

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5 380	Continued From page 2 During observation on 2/28/22, at 2:00 p.m. C1 was observed walking around in Woodland apartment with his gait belt on and helmet, with a clear shield covering his mouth. C1 was walking independently with no staff assistance. During observation on 3/1/22, at 10:00 a.m. C1 was observed in Woodland apartment with his helmet and gait belt on walking independently throughout the apartment with no staff walking with him. During observation from 2/28/22, through 3/2/22, the EZ Way lift and nurse on a stick (vital sign machine) remained stored in the same place were C1 had tripped and fell. Also, there were six dresser drawers observed stacked up against the wall next to the EZ Way lift. C1's Face Sheet undated, indicated he had profound intellectual disability, cerebral palsy and legal blindness. C1's Coordinated Services Support Plan (CSSP) dated 10/13/21, indicated a diagnosis of autism and C1 would pace back and forth or wander around in the home. The CSSP indicated due to lack of sleep, C1 being legally blind, and his feet pointing inward, C1 was at extremely high risk for falls. The CSSP directs staff to walk with C1 holding his gait buckle to prevent falls. C1's Physician Orders indicated on 1/6/22, 1:1 supervision required due to high risk of falls and impulsive behavior. In addition, C1's Physician Orders indicated a new helmet with face shield. C1's Health Needs Record (HNR) dated 2/08/22, indicated C1 was identified as a high fall risk and C1 had inverted lower extremities. The HNR	5 380		

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5 380	Continued From page 3 indicated C1 was unable to walk independently, as he was a 1:1 for safety precautions. Review of C1's falls indicated the following: 2/17/22, Fall 8:00 a.m. C1 tripped on EZ Way (mechanical transferring device) and had his old helmet on, not the new one with shield. C1 sustained a scratch on right side of nose, with blood coming from his mouth. C1 was walking independently at time of fall. C1 sent to urgent care, no acute concerns. 2/19/22, Fall 12:00 p.m. witnessed. C1 had helmet on and gait belt. C1 was bleeding from old wound. First Aid was provided. 2/23/22, Fall at 9:45 a.m. C1 tripped and fell in living room. Unclear if C1 was ambulating independently. C1 was bleeding from old wound, pressure applied. First aid provided. 3/1/22, Fall at 3:40 p.m. staff observed C1 walking towards living room alone, and staff followed C1 at the time he fell. Review of all fall reports lacked evidence an internal review was completed to determine if CSSP was followed, if C1 was re-assessed post fall, or if fall interventions were implemented to prevent future falls. During an interview 2/28/22, at 4:00 p.m. direct support staff (DSS)-A stated, she was not aware C1's HNR indicated C1 was not supposed to walk independently and was supposed to be 1:1's. DSS-A stated, "It is impossible to walk with [C1] at all times, we just don't have enough staff." DSS-A stated with the fall where C1 tripped on the EZ Way, it was in the back of the apartment	5 380		

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5 380	Continued From page 4 against the wall. DSS-A pointed at the EZ Way and stated, "it was right there, where it is now." DSS-A stated C1 tripped over the vital sign machine (nurse on a stick) while the nurse was taking another client's blood pressure. DSS-A pointed to the nurse on a stick, which was next to the cabinet, across from the kitchen table. During interview on 2/28/22, at 4:45 p.m. DSS-B stated she was not aware of C1's HNR indicating he required 1:1 and was not to ambulate independently. DSS-B stated the dresser drawers have been in the hall stacked against the wall for weeks because another client received a new dresser, and no one removed the old one. During interview on 3/1/22, at 11:35 a.m. nurse case manager NCM-A stated C1 ideally should have 1:1 to prevent falls and had a doctor's order but they cannot follow the order. NCM-A stated management was aware of the order and know they can't follow the doctor order. NCM-A added they can see C1 walking alone in the apartment all the time. NCM-A stated they don't have enough staff to provide 1:1 staff for C1. NCM-A stated the 5-Day investigations for C1's falls have not been done and that was the responsibility of the operating administrator, who walked off the job awhile back, so no one has been doing them. She stated they have no falls committee to discuss the falls and the facility has a broken system. When asked if C1 was re-assessed after the falls, NCM-A stated no one looked at the incident report or reviewed concerns related to the falls such as medical or environmental factors. During interview on 3/1/22, at 2:00 p.m. the PAQA stated the operations administrator used to complete the internal reviews after a client falls	5 380		

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5 380	Continued From page 5 within five days of the incident. The PAQA stated the operations administrator had quit, without notice, one month ago. PAQA stated staff have found some of the incident reports on staff members desks, not filled out, and should have been completed. Homeward Bound Policy and Procedure on Reviewing Incidents and Emergencies, dated 10/15, indicated the following: The internal review will be completed using the Internal Review form and will include an evaluation of whether: 1. Related policies and procedures were followed. 2. The policies and procedures were adequate. 3. If there is need for additional staffing. 4. If the reported event is similar to past events with the individuals or services involved. In addition, the policy indicated if there is a need for corrective action by the license holder to protect the health and safety of the individuals served, a corrective action plan will be designed to correct current lapses and prevent future lapses in performance by HBI staff if any.	5 380		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 24, 2022

Administrator
Homeward Bound Brooklyn Park
7839 Brooklyn Blvd
Brooklyn Park, MN 55445

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: YKSR11

Dear Administrator:

The above facility was surveyed on February 28, 2022 through March 11, 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 one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the first page of the order form should be signed and returned 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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susie Haben. A written plan for correction of licensing orders is not required.

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.

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