STATE LICENSING COMPLIANCE REPORT

Report #: HL23749002C

Date Concluded: September 21, 2021

Name, Address, and County of Facility Investigated:
Dr. Thomas H Johnson HWS
2221 West 55th Street
Minneapolis, MN 55419
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Danyell Eccleston, RN

Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23749	A. BUILDING: _____ B. WING _____	C 09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	2221 WEST 55TH STREET MINNEAPOLIS, MN 55419

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, the Minnesota Department of Health issued correction orders pursuant to an investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On September 9, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL23749002C. At the time of the investigation, there were #5 clients receiving services under the assisted living facility. The following correction orders are issued for #HL23749002C, tag identification 0510.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.41, subd. 3, the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.41, subd. 3.	
0 510 SS=I	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19. The facility failed to ensure visitors entering or re-entering the building were screened for COVID-19 with documented temperatures and symptom screening questions. The facility failed to ensure that staff did not work at the facility and with residents during their contagious period. The facility also failed to report positive COVID test results of residents and staff, and failed to report all testing results that were conducted by the facility, to MDH. This had the potential to affect all 5 of 5 residents, staff, and visitors of the facility. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 510		

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0 510	Continued From page 2 has affected or has potential to affect a large portion or all of the clients). Findings include: The Minnesota Department of Health's (MDH) electronic COVID-19 Toolkit (COVID-19 Toolkit: Information for Long-term Care Facilities (state.mn.us): Information for Long Term Care Facilities, dated March 8, 2021, indicated the following on page 7: Screen all staff for fever and symptoms of illness before starting each shift. In addition to staff, conduct health screening for other essential health care personnel including therapy personnel, hospice, home care, dialysis, ombudsman, state surveyors, chaplain at end of life, mortician, etc. Conduct assessment for fever and ask about new symptoms of illness (measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste or smell). Review of facility policy and procedure titled "COVID Policy and Procedures", undated, indicated on page 5, "Active screening means that a trained person should physically monitor temperature of people entering the building and ask questions regarding other COVID 19 related symptoms," and on page 6, "Visitors, including compassionate care/essential care visits, and vendors will be screened at the entrance." On September 9, 2021, at 10:00 A.M., an evaluator from the Minnesota Department of Health entered the facility and facility staff members did not take the evaluator's temperature or ask COVID-19 screening questions. During interview on September 16, 2021, at 3:00	0 510		

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0 510	Continued From page 3 P.M., the facility director (FD)-A stated visitors should be screened which consists of a temperature check and questions regarding symptoms and exposures, which is documented on a form that is kept at the facility. During interview on September 17, 2021, at 1:30 P.M., registered nurse (RN)-C stated staff members screen outside persons for COVID-19 when they enter the facility, and that screening is written on paper. The Minnesota Department of Health's (MDH) electronic COVID-19 Toolkit (COVID-19 Toolkit: Information for Long-term Care Facilities (state.mn.us): Information for Long Term Care Facilities, dated March 8, 2021, indicated the following, on page 22, "Exclusion of ill staff members, with suspected COVID-19 or other clinical illnesses. No staff should work while sick. Exclusion of staff with confirmed COVID-19, regardless of whether they have signs or symptoms of illness. If all staff are tested, some may test positive. Even if they are not sick, they must stay out of work for a minimum of 10 days." Review of facility policy and procedure titled COVID Policy and Procedures, undated, indicated on page 9, "We will obtain consent and authorization from staff to perform testing. If a staff person refuses testing and has signs and symptoms of COVID 19, they will be prohibited from entering the building until the return-to-work criteria is met. If outbreak testing has been triggered and a staff member refuses testing, the staff member should be restricted from entering the building until the procedures for outbreak testing have been completed."	0 510		

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0 510	Continued From page 4 Review of facility COVID testing documentation for staff members indicated home health aide (HHA)-E refused testing on August 23, 2021 and had symptoms of body aches and upset stomach. On August 25, 2021, HHA-E tested positive with symptoms of body aches and chills, and on September 1, 2021, refused testing and was asymptomatic. Review of facility document titled "Schedule 2221" indicated HHA- E was scheduled to work at the facility from 7:00 A.M. - 7:30 P.M on August 23-26, August 30-31, September 1-2, September 6-9, September 13-16, September 20-23, and September 27-30, 2021. Review of facility documents titled "Changes to August & Sept 2221" indicated HHA-E did not work on August 26 or August 30 and did not have any changes to his schedule in September. During interview on September 16, 2021, at 3:00 P.M., the facility director (FD)-A stated the document titled "Scheduled 2221" reflected the staffing schedule for August and September 2021 and that any changes to staffing are indicated on the "Changes to August & Sept 2221" document. FD-A stated staff members that are symptomatic are to stay away from the facility for 14 days and need to have a confirmatory test completed and if positive. FD-A stated staff members that test positive with the rapid antigen test are sent to a clinic for a confirmatory test and need to stay away from the facility for 14 days and there have been no instances of this scenario occurring at the facility. The Minnesota Department of Health's (MDH)	0 510		

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0 510	Continued From page 5 electronic guidance titled "Reporting Results of COVID-19 Tests Performed Inside Your Long-term Care Facility", updated July 2, 2021 (Reporting Results of COVID-19 Tests Performed Inside Your Long-term Care Facility (state.mn.us) , on page 1, indicated the following: "If you conduct the testing inside your facility, you are acting as a laboratory and must report results to the Centers for Disease Control and Prevention (CDC) or Minnesota Department of Health (MDH). These instructions are for organizations using POC antigen tests provided by the federal Department of Health and Human Services (HHS). All COVID-19 test results, positive and negative, performed on a laboratory testing platform inside your facility must be reported within 24 hours." The guidance also indicated the following on page 3, "Additional clinical and demographic information on positive cases must be reported as soon as possible via a secure web form. This information is required for all resident and staff cases associated with your facility, whether tested with a POC antigen test or with RT-PCR by a reference laboratory." Review of facility policy and procedure titled COVID Policy and Procedures, undated, indicated the following, on page 7, "A confidential list will be maintained of who was tested and who was not tested and why. We will report the total number tested to MDH in the RedCap survey using the survey identifier (return code in upper right-hand corner of the form) to re-enter the survey.", "If we have any positive COVID 19 cases, then we will test once a week until there are no positive cases for 14 days." Review of facility document titled "COVID Testing	0 510		

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0 510	Continued From page 6 (Staff)" for August and September, 2021, indicated the first testing of a staff member was on August 23, 2021, and additional staff testing was conducted on August 24, 25, 26, 27, 31 and September 1, 2, 3, 6, 7, 9, 10, 2021. The document indicated ULP-E tested positive on August 23, 2021, and ULP-F tested positive on August 24, 2021. Review of facility document titled "COVID Testing - 2221 Residents" for August and September, 2021, indicated resident testing was at a hospital on August 21, 2021 and additional resident testing was attempted on August 23, 25, 27, 30 and September 4, 7. The document indicated resident 1 (R1) tested positive at a hospital on August 21, 2021, and R2, R3, R4, and R5 tested positive at the facility on August 23, 2021. During interview on September 16, 2021, at 3:00 P.M., FD-A stated the facility is conducting testing and utilizing rapid antigen testing and RN-B was conducting and reporting results to MDH. During interview on September 17, 2021, at 9:58 A.M RN-B stated she was not conducting testing and RN-C was conducting the swabbing for testing. RN-B also stated she initially reported that the facility was experiencing an outbreak to the RedCap website but did not enter any further information. RN-C stated that RN-D would have more information about reporting to MDH. During interview on September 17, 2021, at 1:30 P.M. RN-C stated she read the test results and conducted most of the test swabbing for the facility, but RN-C also assisted with swabbing. RN-C stated positive test results have been reported to MDH by emailing an Excel document. RN-C was unable to provide the name or email	0 510		

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0 510	Continued From page 7 address of where the documentation was sent. During a correspondence with a MDH epidemiologist (E)-D on September 17, 2021 at 2:50 P.M., she stated the facility had not reported any testing information or positive cases to MDH to date despite repeated correspondence from a MDH COVID case manager on how to report information. In an email from RN-C on September 17, 2021, at 6:12 P.M., RN-C indicated that positive COVID findings were documented in a spreadsheet and given to another staff member for submission and she assumed the submission was completed. RN-C indicated that she reviewed the MDH reporting site for the facility and was unable to locate the submission and unable to confirm that documentation was submitted to MDH. Time Period to Correct: Three (3) days.	0 510		