STATE LICENSING COMPLIANCE REPORT

Report #: HL28438001C

Date Concluded: October 26, 2021

Name, Address, and County of Facility Investigated:
Scandia Senior Care LLC
504 East Isle Street
Isle, MN 56342
Mille Lacs County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Angela Vatalaro, 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
	28438	A. BUILDING: _____ B. WING _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA SENIOR CARE LLC	540 EAST ISLE STREET ISLE, MN 56342

(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., the Minnesota Department of Health issued a correction order pursuant to a survey. 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 October 26, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL28438001C. At the time of the survey, there were #6 residents receiving services under the Assisted Living with Dementia Care license. The following correction order is issued for #HL28438001C, tag identification 0510.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which 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. 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.A The letter in the left colunn is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=K	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 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 deficient practice had the potential to affect 6 out of 6 residents. In addition, 2 out of 10 residents died during a Covid-19 outbreak. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). The findings include: During an interview on October 26, 2021, at 10:30 a.m., unlicensed personnel (ULP)-A stated the facility currently had no active cases of COVID-19 in the building and the current resident census was six.	0 510		

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0 510	Continued From page 2 A review of the facility-provided list of residents who tested positive for COVID-19 indicated a census of 10. The list included names and dates of residents who tested positive and residents who tested negative. The same list also identified if residents hospitalized, died, or moved out of the facility. The list indicated: R1 tested negative twice, last tested on October 22, 2021. R2 tested positive on September 25, 2021, death while hospitalized on October 4, 2021. R3 tested positive on September 27, 2021, death while hospitalized on October 6, 2021. R4 tested positive on September 24, 2021. R5 tested negative twice, last tested on October 22, 2021. R6 tested positive on September 25, 2021. R7 tested positive on September 25, 2021, moved home on October 4, 2021. R8 tested positive on September 25, 2021. R9 tested positive on September 30, 2021, moved out of the facility on October 14, 2021. R10 tested positive on October 1, 2021. R2 and R3's death records indicated cause of death included covid infection. Personal Protective Equipment The facility failed to ensure staff wore personal protective equipment (PPE) per CDC and the MDH guidelines. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative	0 510		

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0 510	Continued From page 3 residents to wear a medical grade well fitting facemask and eye protection. The Minnesota Department of Health Infection Prevention and Control: COVID-19 electronic guidance for infection prevention and control in health care settings, dated August 2, 2021, indicated MDH recommends eye protection for all health care workers (HCW) in all resident care areas and when providing direct care. The Centers for Disease Control and Prevention (CDC) COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated September 10, 2021, indicated eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. During an observation on October 26, 2021, at 10:25 a.m., ULP-A greeted the evaluator at the facility's front entrance. ULP-A wore a facemask and did not have on eye protection. The facility entrance led into a communal dining area, off the communal dining area was a kitchen. One resident sat in a wheelchair at a dining table. A second resident walked independently in the dining area. During an observation on October 26, 2021, at 10:35 a.m., a resident walked into the kitchen area. The resident took a beverage and a muffin, afterwards returned to a dining table. ULP-B observed in the kitchen. ULP-B wore a facemask and did not have on eye protection. During an observation on October 26, 2021, at 10:35 a.m., ULP-B pushed a resident in a	0 510		

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0 510	Continued From page 4 wheelchair from the dining table to the resident's room. While in the resident's room, ULP-B made the residents bed. ULP-B applied a transfer belt and assisted the resident from sit to stand position and transferred the resident to the edge of bed. ULP-B removed the resident's shoes and assisted the resident to lie down. ULP-B wore a facemask and did not have on eye protection. During an observation on October 26, 2021, at 10:40 a.m., ULP-A entered a resident's room. The resident was lying in a hospital bed. ULP-A removed the residents meal plate from the overbed table and brought it into the kitchen. ULP-A returned to the resident's room with a package of premoistened wipes. ULP-A cleaned the residents hands using the premoistened wipes. ULP-A wore a facemask and did not wear eye protection. During an interview on October 26, 2021, at 10:45 a.m., ULP-A and ULP-B both verified they did not wear eye protection. Both ULP's stated they did not wear eye protection routinely. ULP-A stated when the facility had COVID-19 positive residents on transmission based precautions, staff wore eye protection before entering COVID-19 positive residents rooms. She stated staff did not wear eye protection otherwise. During an interview on October 26, 2021, at 10:55 a.m., ULP-A stated four facility staff members tested positive for COVID-19 during the facility outbreak. During an interview on October 26, 2021, at 2:15 p.m., registered nurse (RN)-C stated it was up to the staff members own discretion to wear eye protection, and staff decided if they wanted to wear eye protection or not. RN-C stated she did	0 510		

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0 510	Continued From page 5 not enforce staff to wear eye protection before or after the facility's COVID-19 outbreak. RN-C stated it was an expectation staff wore eye protection when in a COVID-19 positive resident's room. The facility-provided policy titled COVID-19 Pandemic Emergency Action Plan, dated August 31, 2020, indicated instruction for staff to wear safety glasses or face shield when doing cares. The same policy did not include instructions for eye protection for all health care workers (HCW) during all resident encounters. Resident Screening The Centers for Disease Control and Prevention (CDC) COVID-19, Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 Spread in Nursing Homes and Long-Term Care Facilities, dated September 10, 2021, indicated to actively monitor residents at least daily for fever, symptoms consistent with COVID-19, and oxygen saturation via pulse oximetry. During an interview on October 26, 2021, at 10:55 a.m., ULP-A and ULP-B both stated residents screened for COVID-19 once daily. ULP-A and ULP-B both stated resident screening consisted of a daily temperature check. During an interview on October 26, 2021, at 11:00 a.m., ULP-A verified staff documented resident COVID-19 screening on a facility document titled Communication Sheet. ULP-A stated staff did not ask COVID-19 symptom questions or check resident's oxygen saturation during the screening process, staff checked daily temperatures.	0 510		

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0 510	Continued From page 6 A review of the document titled Communication Sheet indicated an area for staff to document a daily temperature measurement. The document did not include instructions for daily resident screening for COVID-19, oxygen saturation measurement, or symptom monitoring consistent with COVID-19. R1 R1's diagnoses included dementia. R1 started receiving services January 12, 2021. R1's profile indicated R1 was independent with transfers, ambulation, toileting, incontinence, eating, dressing, grooming, and required stand by assistance with bathing. R1's screening indicated on the document titled Communication Sheet included the following: On October 19, 2021, temperature measurement of 97.5. On October 20, 2021, temperature measurement of 97.0. On October 21, 2021, temperature measurement of 97.9. On October 22, 2021, temperature measurement of 98.0. On October 23, 2021, temperature measurement of 98.0. On October 24, 2021, temperature measurement of 97.3. On October 25, 2021, temperature measurement of 97.6. R4 R4's diagnoses included progressive supranuclear palsy (a neurodegenerative condition). R4 started receiving services June 8, 2020. R4's profile indicated R4 required assistance with transfers, toileting, incontinence, dressing, grooming, and bathing.	0 510		

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0 510	Continued From page 7 R4's screening indicated on the document titled Communication Sheet included the following: On October 19, 2021, temperature measurement of 98.2. On October 20, 2021, temperature measurement of 97.9. On October 21, 2021, temperature measurement of 97.3. On October 22, 2021, temperature measurement of 98.0. On October 23, 2021, temperature measurement of 97.3. On October 24, 2021, did not include temperature measurement. On October 25, 2021, temperature measurement of 98.3. R5 R5's diagnoses included history of seizures and cerebrovascular accident (stroke). R5 started receiving services November 8, 2019. R5's profile indicated R5 was independent with transfers, ambulation, toileting, eating, dressing, grooming, and received assistance with bathing. R5's screening indicated on the document titled Communication Sheet included the following: On October 19, 2021, temperature measurement of 97.6. On October 20, 2021, temperature measurement of 97.6. On October 21, 2021, temperature measurement of 98.0. On October 22, 2021, temperature measurement of 97.8. On October 23, 2021, temperature measurement of 98.0. On October 24, 2021, did not include temperature measurement.	0 510		

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0 510	Continued From page 8 On October 25, 2021, temperature measurement of 97.2. R6 R6's diagnoses included chronic obstructive pulmonary disease (COPD), and macular degeneration. R6 started receiving services September 15, 2021. R6's profile indicated R6 required assist of 1 to 2 for mechanical lift transfers. R6 required assistance with toileting, incontinence, dressing, grooming, and bathing. R6's screening indicated on the document titled Communication Sheet included the following: On October 19, 2021, temperature measurement of 97.9. On October 20, 2021, temperature measurement of 97.6. On October 21, 2021, temperature measurement of 98.4. On October 22, 2021, did not include temperature measurement. On October 23, 2021, did not include temperature measurement. On October 24, 2021, temperature measurement of 98.0. On October 25, 2021, did not include temperature measurement. R8 R8's diagnoses included cerebrovascular accident (stroke) and hypertension. R8 started receiving services June 8, 2018. R8's profile indicated R8 was independent with transfers, ambulation, toileting, eating, dressing, grooming, and required assistance with bathing. R8's screening indicated on the document titled Communication Sheet included the following: On October 19, 2021, temperature measurement	0 510		

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0 510	Continued From page 9 of 98.0. On October 20, 2021, temperature measurement of 97.3. On October 21, 2021, temperature measurement of 97.0. On October 22, 2021, temperature measurement of 97.0. On October 23, 2021, did not include temperature measurement. On October 24, 2021, did not include temperature measurement. On October 25, 2021, temperature measurement of 97.2. R10 R10's diagnoses included chronic obstructive pulmonary disease (COPD) and bilateral below knee amputation. R10 started receiving services July 1, 2021. R10's profile indicated R10 was independent with transfers, toileting, eating, dressing, grooming and bathing. R10's screening indicated on the document titled Communication Sheet included the following: On October 19, 2021, temperature measurement of 97.7. On October 20, 2021, temperature measurement of 97.0. On October 21, 2021, temperature measurement of 98.3. On October 22, 2021, temperature measurement of 97.5. On October 23, 2021, did not include temperature measurement. On October 24, 2021, temperature measurement of 98.0. On October 25, 2021, temperature measurement of 98.0. During an interview on October 26, 2021, at 11:40	0 510		

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0 510	Continued From page 10 p.m., ULP-B stated around the timeframe of the facility COVID-19 outbreak, resident screening for COVID-19 consisted of daily temperature checks. She stated staff took a full set of resident vital signs weekly on bath days which included oxygen saturation readings. During an interview on October 26, 2021, at 2:15 p.m., RN-C stated residents should screen for COVID-19 twice daily. She said the screening includes daily temperature checks. RN-C stated before the facility COVID-19 outbreak, resident screening consisted of daily temperature checks. She said staff checked oxygen saturations weekly. She said staff watched the resident's symptoms and would alert the nurse if a resident showed signs of illness. The facility-provided policy titled COVID-19 Pandemic Emergency Action Plan, dated August 31, 2020, indicated staff took resident's temperatures daily, and monitored residents each shift to ensure they appear in good health. The same policy did not include actively monitoring resident symptoms consistent with COVID-19 and oxygen saturation via pulse oximetry at least daily. Disinfectant Contact/Kill Time The facility failed to ensure high touch surface areas were disinfected effectively using EPA-registered disinfectant. The Centers for Disease Control and Prevention (CDC) COVID-19, Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 Spread in Nursing Homes and Long-Term Care Facilities, dated September 10, 2021, indicated high-touch surface areas and	0 510		

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0 510	Continued From page 11 shared equipment wiped down with Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from List N. During an interview on October 26, 2021, at 10:55 a.m., ULP-A stated staff used Lysol disinfecting wipes EPA-777-114, cleaned surface areas throughout the day, and cleaned tables after meals. ULP-A stated she did not know what the contact time was for the Lysol disinfecting wipes. During an interview on October 26, 2021, at 10:55 a.m., ULP-B stated she did not know what the contact time was for the Lysol disinfecting wipes. A review of List N of the EPA website indicated Lysol disinfecting wipes was an effective disinfectant against COVID-19 with a contact time of two minutes. The facility-provided policy titled COVID-19 Pandemic Emergency Action Plan, dated August 31, 2020, indicated staff must santize tables and chairs between meals and dining shifts. The same policy did not include disinfecting high-touch surface areas and shared equipment using EPA-registered disinfectants including staff education of contact time. TIME PERIOD TO CORRECT- Two (2) days	0 510		