STATE LICENSING COMPLIANCE REPORT

Report #: HL30228001C

Date Concluded: September 2, 2021

Name, Address, and County of Facility Investigated:
Primrose Retirement Community
724 Maple Grove Road
Duluth, MN 55811
Saint Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, RN

Rapid Response Evaluator

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
	30228	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY	724 MAPLE GROVE ROAD DULUTH, MN 55811

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On September 2, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL30228001C. At the time of the investigation, there were #72 residents receiving services under the assisted living license. The following correction orders were issued for #HL30228001C, tag identification 0130, 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.	
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130		

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130		

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130		

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130		

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to include their independent living resident capacity during transition to an assisted living license to meet the requirements of licensure. The assisted living license effective August 1, 2021, indicated a capacity of 42 assisted living residents, 72 lived at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: During an observation on September 2, 2021, at 9:30 a.m., the investigator arrived at the facility's parking lot. The front of the facility observed as a single u-shaped building. The lobby included offices and hallways led north, east, and west. The hallway that led north on the first floor included a kitchen and two dining spaces. During an interview on September 2, 2021, at 11:00 a.m., executive director (ED)-H stated the	0 130		

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0 130	Continued From page 5 resident census was 27 assisted living residents and the facility licensed for a capacity of 42. She stated independent living residents also lived at the facility. During an observation on September 2, 2021, at 11:45 a.m., residents attended communal dining in the two dining room spaces located on the first floor. There were more than 27 residents in attendance at the meal. The facility map indicated the building's layout included two floors and three wings of apartments. The map identified Wing A and Wing B as "Independent/Assisted Living Apartments." Wing C identified as "Assisted Living Apartments." The same map included a hall with a single kitchen located on the first floor and two dining spaces. The resident roster dated September 2, 2021, indicated a census of 72 residents. The same roster indicated Wing A housed 24 independent living residents. Wing B housed 21 independent living residents and five assisted living residents. Wing C housed 22 assisted living residents. During an interview on September 7, 2021, at 10:56 a.m., ED-H verified the facility address and said Wing A, Wing B, and Wing C did not have separate addresses, all wings in the building shared the single address. She said Wing A housed independent living, Wing B housed independent living and five assisted living residents, and Wing C housed assisted living residents. She said both independent and assisted living residents received meals from the same kitchen and ate meals together in the two communal dining spaces. She said all residents shared the facility's community spaces to include	0 130		

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0 130	Continued From page 6 the two communal dining spaces, exercise room, great room, theater room, seating areas, and outside spaces. The facility's assisted living license effective August 1, 2021, indicated a capacity of 42 assisted living beds. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and 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 deficient practice had the potential to effect 72 out of 72 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510		

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0 510	Continued From page 7 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: Personal Protective Equipment The faility failed to ensure staff wore personal protective equipment (PPE) per CDC and the MDH guidelines. The Minnesota Department of Health (MDH) electronic COVID-19 Toolkit, Information for Long-Term Care Facilities, dated March 8, 2021, indicated staff wear a well-fitting facemask at all times, and institute use of eye protection when in resident care areas. The Minnesota Department of Health Infection Prevention and Control: COVID-19 electonic 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. During an observation on September 2, 2021, 9:40 a.m., unlicensed personnel (ULP)-A and ULP-B were at the nurse's station. Both ULP-A and ULP-B wore facemasks, both ULP's did not have on eye protection. During an observation on September 2, 2021, at 9:45 a.m., life enrichment (LE)-C led an exercise activity to residents seated in a circle. LE-C did not have on a facemask or eye protection.	0 510		

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0 510	Continued From page 8 During an observation on September 2, 2021, at 9:50 a.m., ULP-B spoke to a resident at the nurse's station. ULP-B wore her facemask under her nose and she did not have on eye protection. During an observation on September 2, 2021, at 10:00 a.m., cook (C)-D walked down the hall and entered the kitchen. C-D did not have on a facemask. Upon entrance to the kitchen, dining director (DD)-E handed C-D a facemask. During an interview on September 2, 2021, at 10:00 a.m., C-D stated he just arrived to work and verified he did not put on a facemask upon entrance into the facility. C-D put on a facemask. During an observation on September 2, 2021, at 10:05 a.m., assistant director of nursing (ADON)-F sat at the nurse's station. ADON-F wore her facemask under her nose, and she did not have on eye protection. During an interview on September 2, 2021 at 10:05 a.m., ADON-F wore her facemask under her nose as she spoke to the investigator. When asked why she wore her facemask under her nose she stated her facemask kept falling down. ADON-F stated she provided direct care to residents' and applied TED stockings earlier in her shift. ADON-F said it was not appropriate to wear facemasks under the nose. During an observation on September 2, 2021, at 10:20 a.m., ADON-F responded to a call light, entered a resident's room without eye protection and wore her facemask under her nose. ADON-F left the resident's room and returned with wound care supplies. ADON-F wore her facemask under her nose and did not wear eye protection as she	0 510		

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0 510	Continued From page 9 removed a bandage from the resident's arm and redressed a wound. During an interview on September 2, 2021, at 11:00 a.m., director of nursing (DON)-G stated it was an expectation that facility staff wore facemasks when in the facility and wore facemasks over the nose. During an observation on September 2, 2021, at 11:45 a.m., DD-E placed food on plates and set the plates down on the kitchen serving window. DD-E wore his facemask under his nose. During the same observation facility staff members removed plates from the serving window and served residents their meals. The facility staff members wore facemasks but did not have on eye protection as they served residents. During an interview on September 2, 2021, at 12:00 p.m., executive director (ED)-H stated it was an expectation that facility staff wore facemasks while in the facility and wore facemasks over the nose. She stated it was an expectation staff took facemasks off only when eating or drinking during break. She said facility staff do not wear eye protection. She said all staff are required to wear eye protection during a facility COVID-19 outbreak. ED-H said the facility had eye protection available for staff use. During an observation on September 2, 2021, at 12:20 p.m., DD-E wore his facemask under his nose as he prepared plates at the kitchen serving window. During the same observation ED-H verified DD-E wore his facemask under his nose. During an interview on September 2, 2021, at 12:35 p.m. ULP-B stated facility staff only wore eye protection during a facility COVID-19	0 510		

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0 510	Continued From page 10 outbreak. The facility provided policy titled Coronavirus Disease 2019 (COVID-19) Preparedness Prevention Plan, dated July 2021, indicated employees must wear surgical/medical procedure masks over the nose and mouth. The same policy indicated the community would have eye protection supply, however it did not indicate employees wore eye protection in all resident care areas and when providing direct care. Screening Staff The facility failed to ensure that all staff that entered the building actively screened for fever and symptoms of illness before the start of their shift. The Minnesota Department of Health's (MDH) electronic COVID-19 Toolkit: Information for Long Term Care Facilities, dated March 8, 2021, indicated on page 7: Screen all staff for fever and symptoms of illness before starting each shift. A review of the facility's schedule for the morning of September 2, 2021, indicated 14 staff members worked. A review of the facility's Employee Screening log dated September 2, 2021, indicated eight staff members screened for COVID-19. The same Employee Screening log did not include six staff members COVID-19 screening. During an interview on September 2, 2021, at 12:00 P.M., ED-H verified six staff members did not screen the morning of September 2, 2021, before start of shift. She stated it was an expectation that all staff screened before start of	0 510		

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0 510	Continued From page 11 shift and upon entrance into the building. The facility provided policy titled Coronavirus Disease 2019 (COVID-19) Preparedness Prevention Plan, dated July, 2021, indicated employees are required to take their own temperatures daily and perform self-screening at home before coming to work. The facility provided document titled Restrictions Update, dated June 16, 2021, indicated staff screen at points of entry. Screening Residents The licensee failed to conduct active health screening and surveillance of residents for COVID-19 at least daily per MDH guidelines. The Minnesota Department of Health's (MDH) electronic COVID-19 Toolkit: Information for Long Term Care Facilities, dated March 8, 2021, indicated MDH guidance for identifying infections early included the following: Actively screen all residents for fever (>100.0 Fahrenheit) and symptoms consistent with COVID-19. The same document indicated routine use of pulse oximetry to screen for new or worsening hypoxia may identify infected residents. During an interview on September 2, 2021, at 10:00 a.m., ADON-F stated residents did not screen for COVID-19 daily. During an interview on September 2, 2021, at 11:00 a.m., DON-G stated residents did not screen for COVID-19 daily. She stated facility staff kept a close eye on residents to see if they present with symptoms.	0 510		

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0 510	Continued From page 12 During an interview on September 2, 2021, at 11:25 a.m., ULP-A stated she worked at the facility for approximately two months. She said since her start date residents had not screened for COVID-19. She said if a resident had shortness of breath, cough, or dizziness she would alert the nurse. During an interview on September 2, 2021, at 12:00 p.m., ED-H stated the facility does not conduct daily screening of residents for COVID-19. She said when the facility did conduct daily COVID-19 screenings, residents screened twice daily. During an interview on September 2, 2021, at 12:45 p.m., ED-H stated the last time residents screened for COVID-19 was approximately March of 2021. She stated she received direction from her corporate office that residents did not need to screen daily. A review of the facility's Twice Daily-Primrose Resident-COVID-19 Symptom Screening Log for the week of March 7, 2021 through March 13, 2021, included a resident's name, seven separate columns for days of the week and rows that included temperature readings, oxygen saturation readings, and symptom questions. The same document's oxygen saturation readings for the week of March 7, 2021 through March 13, 2021 left blank. The facility provided policy titled Coronavirus Disease 2019 (COVID-19) Preparedness Prevention Plan, dated July 2021, indicated residents would be monitored for COVID-19 signs and symptoms. The same policy did not include actively screening residents at least daily.	0 510		

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0 510	Continued From page 13 TIME PERIOD TO CORRECT- Two (2) days	0 510		