STATE LICENSING COMPLIANCE REPORT

Report #: HL30434001C

Date Concluded: September 24, 2021

Name, Address, and County of Facility Investigated:
Saint Ann's Home
330 East 3rd Street
Duluth, MN 55805
Saint Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, RN
Lori Pokela, RN
Special Investigators

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
	30434	A. BUILDING: _____ B. WING _____	C 09/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

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0 000	Initial Comments Initial comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G., the Minnesota Department of Health issued a correction order(s) 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 September 23, 2021, the Minnesota Department of Health initiated an investigation of complaint HL30434001C. At the time of the survey, there were 103 residents receiving services under the assisted living license. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order is issued for HL30434001C, tag identification 510. On September 24, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL30434001C. At the time of the survey, there were #101 residents receiving services under the assisted living license. The following immediacy of the correction order, tag 510 was removed. The following correction order	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.	

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0 000	Continued From page 1 remain issued, tag 510.	0 000		
0 510 SS=I	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 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 103 out of 103 residents. This practice resulted in a level three violation (a violation that harmed a resident'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 has affected or has potential to affect a large portion of all residents). Findings Include:	0 510		

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0 510	Continued From page 2 The Centers for Disease Control and Prevention: Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing homes for Nursing Homes and Long-Term Care Facilities, dated September 10, 2021, indicated fully vaccinated residents who have had close contact with someone with SARS-CoV-2 infection should be tested as described in the testing section. The same document indicated all HCP (Healthcare personnel) who have had a higher-risk exposure and residents who have had close contacts, regardless of vaccination status, should be tested immediately as described in the testing section The CDC website updated September 18, 2021, titled Quarantine and Isolation indicated fully vaccinated people should get tested 3-5 days after their exposure and quarantine until a negative test result or for 10 days without testing. During an interview on September 23, 2021, at 9:55 a.m., unlicensed personnel (ULP)-A stated R1 tested positive for COVID-19 and was on transmission-based precautions. During an interview on September 23, 2021, at 11:00 a.m., director of nursing (DON)-B stated R1 was vaccinated against COVID-19. R1's COVID-19 test administered on September 17, 2021, resulted positive on September 19, 2021. R1 started isolation September 19, 2021. She stated during her contact tracing investigation she identified two staff members, ULP-C and ULP-D, both vaccinated with high-risk exposure. She stated the facility had not operationalized COVID-19 contact tracing testing because they did not have supply of test kits and was currently waiting on supply to arrive. During the same	0 510		

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0 510	Continued From page 3 interview, DON-B stated facility staff stopped wearing eye protection a month ago. On September 19, 2021, the facility staff started to wear eye protection again after R1's COVID-19 test resulted positive. A review of R1's vaccination record indicated R1 received a dose of Moderna vaccine on January 21, 2021, and a second dose on February 18, 2021. A review of ULP-C's Risk Assessment for Health Care Workers Potentially Exposed to COVID-19 in Minnesota indicated the date of most recent exposure was September 14, or September 15, 2021. A review of ULP-C's work schedule indicated ULP-C worked September 16, 18, 19, 21, 22, 2021. A review of ULP-D's Risk Assessment for Health Care Workers Potentially Exposed to COVID-19 in Minnesota indicated the date of most recent exposure was September 17, 2021. A review of ULP-D's work schedule indicated ULP-D worked September 17, 18, 19, 20, 21, 22, 2021. A review of R1's facility contact tracing investigation indicated the facility identified R2, R3, R4, sat at R1's dining room table during exposure period. The same investigation identified six additional residents as being "nearby" R1's table. A review of the facility's Exposure to Positive Resident excel worksheet indicated dates and time duration of R2, R3, and R4's COVID-19	0 510		

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0 510	Continued From page 4	0 510		

exposure as follows:.

R2
September 10, 2021, 25 minutes.
September 13, 2021, 21 minutes.
September 14, 2021, 11 minutes.
September 15, 2021, 17 minutes.
September 16, 2021, 24 minutes.
September 16, 2021, 30 minutes.
September 17, 2021, 17 minutes.
September 17, 2021, 26 minutes.

R3
September 10, 2021, nine minutes.
September 13, 2021, 29 minutes.
September 13, 2021, six minutes.
September 14, 2021, 12 minutes.
September 14, 2021, eight minutes.
September 15, 2021, nine minutes.
September 16, 2021, 27 minutes.
September 17, 2021, seven minutes.

R4
September 13, 2021, 19 minutes.
September 13, 2021, 11 minutes.
September 14, 2021, nine minutes.
September 14, 2021, 11 minutes.
September 16, 2021, 19 minutes.
September 16, 2021, 28 minutes.
September 17, 2021, 11 minutes.
September 17, 2021, 13 minutes.

During an interview on September 23, 2021, at 2:23 p.m. DON-B stated after the facility identified R2, R3, R4 as high risk exposure they did not quarantine or restrict R2, R2, R4 to their rooms because all three residents were vaccinated against COVID-19. DON-A stated ULP-C and ULP-D both identified as high-risk exposure, had not tested for COVID-19 and worked at the facility

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0 510	Continued From page 5 post exposure. During an interview on September 23, 2021, at approximately 2:45 p.m., DON-B stated the facility's test kits just arrived onsite. During an interview on September 23, 2021, at 4:33 p.m., DON-B stated R2, R3, and R4 tested for COVID-19 at a clinic outside of the facility however they had not received results back yet and R2, R3, and R4 were not quarantined or restricted to their rooms. On September 23, 2021, at 4:55 p.m., the facility was informed of an immediate correction order initiated due to lack of quarantine and testing of identified high risk exposed residents and staff. The facility-provided policy titled COVID-19 Infection Prevention and Control Plan, undated, did not include quarantine and testing instructions for exposed vaccinated residents and staff. TIME PERIOD TO CORRECT: IMMEDIATE ********** ********** An immediate order was identified due to the facility's failure to quarantine and test high-risk exposed residents and staff. The immediate order began on September 23, 2021, at 4:55 p.m., and immediacy was removed during a follow-up visit on September 24, 2021, at 2:04 p.m. On September 24, 2021, noncompliance issues remained at scope and severity level of F, widespread-potential for harm. Findings Include: Screening Residents	0 510		

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0 510	Continued From page 6 The facility failed to conduct active health screening and surveillance of residents for COVID-19 at least daily per MDH guidelines. In addition, the facility failed to increase monitoring from daily to every shift after R1's COVID-19 test resulted positive on September 19, 2021. 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 at least daily. The same document indicated routine use of pulse oximetry to screen for new or worsening hypoxia may identify infected residents. The Centers for Disease Control and Prevention: Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing homes for Nursing Homes and Long-Term Care Facilities, dated September 10, 2021, indicated because of the risk of unrecognized infections among residents, a new case of SARS-CoV-2 infection in any HCP or in a resident should be evaluated as a potential outbreak. The same document indicated to increase monitoring of all residents from daily to every shift, to rapidly detect those with new symptoms. During an interview on September 23, 2021, at 9:55 a.m., ULP-A stated R1 tested positive for COVID-19 and was on transmission-based precautions. During an interview on September 23, 2021, at 11:00 a.m., DON-B stated R1's COVID-19 test	0 510		

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0 510	Continued From page 7 administered on September 17, 2021, resulted positive on September 19, 2021. DON-B stated residents screened for COVID-19 twice daily. R2's medical record was reviewed. R2's record did not include diagnoses. R2's service plan indicated R2 required assistance with housekeeping, laundry, and medication administration. R2's Symptom Screening Tracking for the week of September 16, 2021, to September 23, 2021, indicated R2 screened once daily for shortness of breath, cough, fever, temperature, and O2 saturations on the following dates: September 16, 2021. September 17, 2021. September 18, 2021. September 19, 2021. September 20, 2021. September 21, 2021. September 22, 2021. R3's medical record was reviewed. R3's record did not include diagnoses. R3's service plan indicated R3 required assistance with housekeeping, laundry, and medication administration. R3's Symptom Screening Tracking for the week of September 16, 2021, to September 23, 2021, indicated R3 screened once daily for shortness of breath, cough, fever, temperature, and O2 saturations on the following dates: September 17, 2021. September 19, 2021. September 20, 2021. September 21, 2021. September 22, 2021.	0 510		

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0 510	Continued From page 8 R4's medical record was reviewed. R4's record did not include diagnoses. R4's service plan indicated R4 required assistance with housekeeping, laundry, and medication administration. R4's Symptom Screening Tracking for the week of September 16, 2021, to September 23, 2021, indicated R2 screened once daily for shortness of breath, cough, fever, temperature, and O2 saturations on the following dates: September 16, 2021. September 17, 2021. September 18, 2021. September 19, 2021, on September 19, 2021, R4's temperature and O2 saturations left blank. September 20, 2021. September 21, 2021. September 22, 2021. R5's medical record was reviewed. R5's diagnoses included diabetes and mild cognitive impairment. R5's service plan indicated R5 required assistance with laundry and medication administration. R5's Symptom Screening Tracking for the week of September 16, 2021, to September 23, 2021, indicated R5 screened once daily for shortness of breath, cough, fever, temperature, and O2 saturations on the following dates: September 19, 2021. September 20, 2021. R6's medical record was reviewed. R6's diagnoses included depression, and bipolar disorder. R6's service plan indicated R6 required assistance with laundry, housekeeping, morning cares, and medication administration.	0 510		

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0 510	Continued From page 9 R6's Symptom Screening Tracking for the week of September 16, 2021, to September 23, 2021, indicated R6 screened once daily for shortness of breath, cough, fever, temperature, and O2 saturations on the following dates: September 16, 2021. September 17, 2021. September 18, 2021. September 19, 2021. September 20, 2021. September 21, 2021. September 22, 2021. R7's medical record was reviewed. R7's record did not include diagnoses. R7's service plan indicated R7 required assistance with laundry, housekeeping, morning cares, and medication administration. R7's Symptom Screening Tracking for the week of September 16, 2021, to September 23, 2021, indicated R7 screened once daily for shortness of breath, cough, fever, temperature, and O2 saturations on the following dates: September 16, 2021. September 17, 2021. September 18, 2021. September 19, 2021. September 21, 2021. September 22, 2021. R8's medical record was reviewed. R8's diagnoses included asthma, hypertension, and chronic kidney disease. R8's service plan indicated R8 required assistance with laundry. R8's Symptom Screening Tracking for the week of September 16, 2021, to September 23, 2021, indicated R8 screened once daily for shortness of breath, cough, fever, temperature, and O2	0 510		

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0 510	Continued From page 10 saturations on the following dates: September 18, 2021. September 20, 2021. September 21, 2021. R9's medical record was reviewed. R9's diagnoses included prostate cancer and kidney stones. R9's service plan indicated R9 required assistance with laundry, medication management, and stand by assist with activities of daily living. R9's Symptom Screening Tracking for the week of September 16, 2021, to September 23, 2021, indicated R9 screened once daily for shortness of breath, cough, fever, temperature, and O2 saturations on the following dates: September 16, 2021. September 18, 2021. September 19, 2021. September 21, 2021. September 22, 2021. R10's medical record was reviewed. R10's diagnoses included acute kidney failure and anemia. R10's service plan indicated R10 required assistance with laundry and medication assistance. R10's Symptom Screening Tracking for the week of September 16, 2021, to September 23, 2021, indicated R10 screened once daily for shortness of breath, cough, fever, temperature, and O2 saturations on the following dates: September 19, 2021. September 20, 2021. September 22, 2021, on September 22, 2021, R10's temperature and O2 saturations left blank. During an interview on September 23, 2021, at	0 510		

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2:45 p.m., DON-B verified the facility had not conducted all COVID-19 screenings for R5, R6, and R7.

During an interview on September 23, 2021, at 3:30 p.m., DON-B verified the facility had not conducted all COVID-19 screenings for R8, R9, and R10. She stated when the facility worked short staffed COVID-19 resident screenings got missed.

The facility-provided policy titled COVID-19 Infection Prevention and Control Plan, undated, indicated to actively monitor all residents daily for fever, cough, shortness of breath, and hypoxemia/oxygen saturation. The same policy did not include increasing resident monitoring from daily to every shift if a new case of SARS-CoV-2 infection identified in an HCP or resident.

Discarding Contaminated Personal Protective Equipment (PPE)

The facility failed to ensure staff discarded contaminated PPE properly per the Center for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH) guidelines. R1 was on transmission based precautions. In the facility's hallway outside of R1's room an open barrel observed containing used PPE.

The MDH document titled, Covid-19 Toolkit, Information for Long Term Care Facilities, dated March 8, 2021, indicated on page 10 facilities should educate staff on PPE donning and doffing (putting on and taking off) practices.

The Centers for Disease Control and Prevention:

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0 510	Continued From page 12 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings, dated July 2019, indicated before leaving the patients room remove and discard PPE. R1's nurse notes dated September 20, 2021, indicated R1 had COVID-19 positive lab result. During an observation and interview on September 23, 2021, at 11:20 a.m., ULP-F discarded a used (PPE) isolation gown in an open receptacle located in the facility's hallway. When ULP-F was asked about the receptacle, ULP-F stated used gowns were removed in the facility hallway after use and discarded in the open receptacle to be cleaned and reused. The facility-provided policy titled Infectious Disease Emergencies-Tuberculosis/COVID-19, undated, indicated staff would remove gowns and discard in the proper receptacle for contaminated material. The same policy did not include placement instructions of the receptacle inside the resident's room. Disinfectant Contact/Kill Time The facility failed to ensure high touch surface areas were disinfected effectively using EPA-registered disinfectants. MDH document titled COVID-19 Toolkit, Information for Long Term Care Facilities, dated March 8, 2021, indicated to clean and disinfectant frequently touched surfaces with an EPA (Environmental Protection Agency) N-list-registered disinfectant with a label indicating effectiveness against human coronavirus or remerging viral pathogens.	0 510		

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0 510	Continued From page 13 During an interview on September 23, 2021, at 9:55 a.m., ULP-E stated she had no knowledge of contact/kill time of the Oxiver Wipe disinfectant used to clean R1's room, equipment, or high touch areas of the facility. During an interview on September 23, 2021, at 11:20 a.m., ULP-F stated she had no knowledge of contact/kill time of the Oxiver Wipe disinfectant used to clean R1's room, equipment, or high touch areas of the facility. Review of the EPA's approved disinfectants, dated September 28, 2021, indicated the Oxiver Wipes had a contact/kill time of one minute and the facility's multipurpose disinfectant had a contact/kill time of 10 minutes. According to the EPA, these contact/kill times covered the COVID-19 virus. The facility-provided policy titled Infectious Disease Emergencies-Tuberculosis/COVID-19, undated, indicated staff must receive information and training regarding infectious disease and prevention. The policy indicated environmental surfaces and reusable equipment were appropriately cleaned. The same policy did not include staff use of EPA N-list registered disinfectants effective against COVID-19 and staff education on contact time. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		