STATE LICENSING COMPLIANCE REPORT

Compliance #: HL34667001C

Date Concluded: November 2, 2021

Name, Address, and County of Licensee Investigated:
The Family Residence
2501 Jefferson Road
Northfield, MN 55057
Rice County

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

Evaluator's Name: Shannan Stoltz, 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
	34667	A. BUILDING: _____ B. WING _____	C 10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FAMILY RESIDENCE	2501 JEFFERSON ROAD NORTHFIELD, MN 55057

(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****** 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 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: OnOctober 27, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL34667001C. At the time of the survey, there were 9 residents receiving services under the assisted living license. The following correction order is issued for HL34667001C, tag identification 0510.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 510	Continued From page 1	0 510		
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 document review, the facility failed to establish and maintain an effective infection control program that complies with accepted health care standards related to COVID-19. The facility failed to have effective screening processes for visitors and staff, failed to provide for effective disinfection of the screening thermometer between uses, and failed to ensure appropriate protective equipment was worn. The deficient practice affected facility staff, Minnesota Department of Health staff, nine residents who reside at the facility, visitors, outside providers, and families. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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).	0 510		

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0 510	Continued From page 2 Findings include: MDH guidance, updated August 2, 2021, indicated that all facility staff should wear a face mask when in the facility. This same guidance indicated that all staff wear eye protection while in a patient care area of the facility. This guidance is for all health care workers, regardless of vaccination status. MDH guidance, updated May 20, 2021, indicated facilities should screen all who enter for signs and symptoms of COVID-19; and deny entry to those with signs or symptoms, or who have had close contact with a COVID-19 infected person in the past 14 days, regardless of the person's vaccination status. On October 27, 2021, at 8:30 am, this Minnesota Department of Health (MDH) investigator arrived at the facility for a complaint investigation. The investigator was let into the facility by an unlicensed personnel (ULP)-A, who was not wearing eye protection, and had her mask pulled down under her nose. ULP-A did not screen the investigator for COVID-19, did not give instructions to self-screen, and instead turned around and walked away. While the investigator stood in the vestibule, another unlicensed personnel (ULP)-B came from a back hallway with no mask or eye protection on, and stated she would contact the nurse to come to the facility. An observation of the visitor screening area showed there were no sanitizing wipes to disinfect the thermometer or pen after each use. Later in the visit, staff showed the investigator the staff screening area, but there was no thermometer, no sanitizing wipes, and the staff	0 510		

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0 510	Continued From page 3 screening sheets were all blank. The staff screening area, located at the back door, placed it right outside two resident's rooms. Both the residents had their doors open the entire visit and were sometimes out in the hallway; which directly exposed them to unscreened staff who have entered the building. Facility staff advised the investigator they do not wear eye protection, they do not screen themselves for COVID-19, that some visitors who enter the building are not screened, and that the visitors were not told to wear face masks. Also during the kitchen visit, plastic single-use medi-cups were observed drying on a large flat pan. RN-C stated the facility sterilizes and re-uses the medi-cups, however, the sterilizer used (EPA reg. no. 1561-11), is not on List N of the Environmental Protection Agency's (EPA) list of approved sanitizers for COVID-19. RN-C threw away all the plastic single-use medi-cups and stated their facility would no longer re-use medi-cups. During onsite conversations with the director of nursing, registered nurse (RN)-C, she stated she thought staff were wearing their masks at all times, but will start monitoring surveillance cameras when she is not in the building. RN-C stated she will reeducate staff to wear masks at all times, and eye protection when in patient care areas. RN-C stated she will move the staff screening area to the front door, and reeducate staff on visitor and self-screening requirements. RN-C stated she will reeducate staff and visitors on visitor mask requirements when in the facility. During the visit, RN-C ordered new safety glasses for all staff, as the ones they had in the facility did not offer appropriate eye protection.	0 510		

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0 510	Continued From page 4 During an interview at 10:57 am, with two family members of a resident, they stated they were let in the back door for this visit, and were not screened for COVID-19 symptoms. Neither family member had on a facemask. One family member stated that although staff had advised her to wear a mask, "I'm a rebel and don't want to." Both family members stated that they, and the resident, were very happy with the care from the facility and staff. They stated they had one or two issues over the course of approximately two years, but when presented to administration, the issues were immediately addressed and remedied. Neither family member knew anything about staff serving left-over food to residents. During an interview at 1:06 pm, with ULP-A, she stated she reported for work at 6:00 am, but did not screen herself until approximately 7:00 am. ULP-A stated she was not aware people are supposed to be screened, and no one told her she had to wear a mask while at work. Later in the interview, ULP-A stated she was advised she had to wear a mask, and was trained to self-screen every day prior to work. ULP-A stated prior to today, she had not been screening herself prior to work. During an interview at 1:17 pm, with ULP-B, she stated the reason she greeted me without a mask on earlier in the day was because she was in the breakroom eating, ran to the door to ensure it was answered, and forgot to put her mask on. ULP-B stated she reported for work at 6:00 am, but did not screen herself until approximately 7:30 am. ULP-B stated she was trained to screen herself and to wear a mask at work. ULP-B stated she always advises visitors to the facility of the mask requirement.	0 510		

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0 510	Continued From page 5 Facility COVID screening sheets for staff were requested, but not provided. RN-C stated she was not able to find any. Facility provided policy Procedure to Using Masks and Eye Protection, updated April 1, 2021, indicated, "Per CDC/MDH guidelines, staff will wear masks and eye protection at all times within building, and throughout resident cares as source protection for Covid". Facility provided policy Employee Health Screening, dated May 2020, indicated, "All employees must perform a health screen prior to start of shift before taking care of residents". The policy cited a specific procedure to follow, as well as reporting criteria. Facility provided policy Disinfecting Reusable Equipment and Environmental Surfaces, dated May 15, 2018, indicated "Reusable equipment and environmental surfaces will be properly disinfected after use." No COVID-specific disinfectant policy was provided. TIME PERIOD TO CORRECT- Two days	0 510		