Electronically Delivered Via Email January 20, 2021

Administrator
Lake Owasso Residence
210 Owasso Blvd North
Shoreview, MN 55126

RE: Event ID: E6PP12

Dear Administrator:

A onsite revisit was completed on January 13, 2021, by a surveyor of the Minnesota Department of Health to follow-up on the deficiencies issued during a survey exited November 25, 2021. The facility was found to be in compliance with the requirements of 42 CFR 483. Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID.)

The Condition of Participation at 42 CFR 483.420 Client Protection and Physical Environment, were found to be back in compliance.

Feel free to contact me with any questions related to this letter.

Sincerely,

Amy Johnson

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121
Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email December 15, 2020

Administrator
Lake Owasso Residence
210 Owasso Blvd North
Shoreview, MN 55126

RE: Event ID: E6PP11

Dear Administrator:

On November 25, 2020 a survey was conducted to investigate a complaint at this facility. The facility was found NOT to be in compliance with the requirements of 42CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

At the time of the complaint investigation the survey team noted one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the complaint invesitgation we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy on November 25, 2020.

One or more of these deficiencies do not meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID): This is listed below.

W406 42 CFR § 483.420 Phusical Enviornment

Federal certification deficiencies are delineated on the enclosed form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC). Ordinarily, a provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.

A PoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by January 19, 2021. we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

Please note, it is your responsibility to share the information contained in this letter and the results of the visit with the President of your facility's Governing Body.

Feel free to contact me with any questions related to this letter.

Sincerely,

Amy Johnson

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 11/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE OWASSO RESIDENCE	**210 OWASSO BLVD NORTH SHOREVIEW, MN 55126**

(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) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 11/23/20, 11/24/20 and 11/25/20 during a COVID-19 Focused Infection Control survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
W 000	INITIAL COMMENTS On 11/23/20, 11/24/20 and 11/25/20 an abbreviated survey was conducted to investigate HG208094C and HG208095C. The facility was found NOT to be in compliance with the requirements of 42CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). HG208094C substantiated with no deficiencies due to the situation was remedied by the resident now being monitored by staff and no harm occurred. HG208095C substantiated with no deficiencies due to the facility staff remedied the error immediately, with no harm occurring. In addition, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.470 (I) (i) Infection Control. The facility was not in full compliance and an IJ was issued. The Condition of Participation for Physical Environment was issued, W406, W455, and all tags under this condition was reviewed.	W 000	POC is on enclosed attachments	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 The Immediate Jeopardy began on 11/24/20, when staff were observed using the same personal protective equipment (PPE) gowns between COVID-19 positive clients and COVID-19 negative clients. The program administrator was notified of the IJ on 11/24/20, at 4:00 p.m. The IJ was removed on 11/25/20, at 4:36 p.m. after verification of a removal plan was implemented.	W 000		
W 268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote dignity by speaking to a client in a person-centered, respectful manner for 1 of 5 clients (C1) who resided in the facility. Findings include: During initial observations on 11/23/20, at 10:31 a.m. designated support personnel (DSP)-1 stated C1, "I don't know what you are waiting for C1, you know lunch is coming up and if you're sitting there still with breakfast, that's going to be a problem." DSP-1 then retrieved a brown piece of paper, took it over to C1 and attempted to have C1 sound out the word 'juice'. When C1 was unable to say it, DSP-1 stated in a rough and demanding voice, "see juice is on the list, so enough with the juice." DSP-1, with the same tone of voice, stated to C1, "if you are sitting there	W 268		

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W 268	Continued From page 2 at lunch time that is your lunch. [C1] what are you doing, why are you staring at me". When interviewed on 11/23/20, at 2:09 p.m. DSP-1 reported his tone was not aggressive or demeaning to C1. When interviewed on 11/23/20, at 3:36 p.m. program director (PD)-1 was informed of the above observation of DSP-1 to C1. PD-1 stated, "I would question [the staff] why they would say it like that" confirming the tone and language used was not person-centered. On 11/24/20, at 10:14 a.m. program supervisor (PM)-1 was also questioned on the DSP-1's comments and she confirmed the tone and language used was "inappropriate" referring to the comments made: "if you are sitting there at lunch time that is your lunch. [C1] what are you doing, why are you staring at me". The facilities' policy titled, Reporting of Maltreatment of Vulnerable Adults, last revised 9/30/20. Under section Definitions, defines Verbal Abuse: refers to any use of insulting, demeaning, disrespectful, oral, written or gestured language directed towards and in the presence of the resident.	W 268		
W 406	PHYSICAL ENVIRONMENT CFR(s): 483.470 The facility must ensure that specific physical environment requirements are met. This CONDITION is not met as evidenced by:	W 406		

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W 406	Continued From page 3 Based on observation, interview and document review, the facility failed to identify and implement interventions to control and reduce the transmission of COVID-19 within 3 households (household 5, 7, and 8) with total of 16 clients, of which 7 were COVID-19 positive and 16 negative. This resulted in an immediate jeopardy when staff were observed to wear isolation gowns while completing high contact personal cares for COVID-19 positive clients (R3), then wearing the same gown to care for COVID-19 negative clients (C4). In addition, staff did not wash their hands after caring for a COVID-19 positive client, before performing cares with a COVID-19 negative client. The Immediate Jeopardy began on 11/24/20, when staff were observed donning the same personal protective equipment (PPE) gowns between COVID positive residents and COVID negative residents. In addition, staff were observed performing improper and inadequate hand washing with soap and water. The program administrator was notified of the IJ on 11/24/20, at 4:00 p.m. The IJ was removed on 11/25/20, at 4:36 p.m. when the facility implemented measures of retraining, re-education, and provided additional gowns for staff. See W455 for additional information: The facility failed to mitigate and reduce the transmission of COVID-19 within 3 households containing a total of 16 residents, of which 7 were COVID-19 positive and the rest negative.	W 406		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the	W 455		

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W 455	Continued From page 4 prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and implement interventions to control and reduce the transmission of COVID-19 within 3 households (household 5, 7, and 8) with total of 16 clients, of which 7 were COVID-19 positive and 16 negative. This resulted in an immediate jeopardy when staff were observed to wear isolation gowns while completing high contact personal cares for COVID-19 positive clients (R3), then wearing the same gown to care for COVID-19 negative clients (C4). In addition, staff did not wash hands after assisiting/caring for a COVID-19 positive client (C3), before performing cares with a COVID-19 negative client (C4) and did not redirect a COVID-19 positive client (C5) to stay in their room. The Immediate Jeopardy began on 11/24/20, when staff were observed using the same personal protective equipment (PPE) gowns between COVID-19 positive clients and COVID-19 negative clients. The program administrator was notified of the IJ on 11/24/20, at 4:00 p.m. The IJ was removed on 11/25/20, at 4:36 p.m. after verification of a removal plan was implemented. Findings Include: Upon entrance interview on 11/23/20, at 8:00 a.m. the receptionist provided a COVID positive tracking regarding clients who tested positive for COVID during their weekly testing. The facility	W 455		

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NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Owasso Residence	210 N. Owasso Blvd., Shoreview, MN 55126

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	The facility failed to promote dignity by speaking to a client in a person-centered, respectful manner for 1 of 5 clients (C1) who resided in the facility.	W 268 SER	The following is in response to the deficiencies noted: Program Staff will complete retraining on identifying and reporting verbal abuse to residents. The training will: 1. Review the definition of verbal abuse. 2. Provide education about what verbal abuse looks like and how to report. 3. Pass a competency test on addressing verbal abuse towards residents. The training will be conducted by or under the direction of the Services coordinator (may train others in how to conduct the training) and documented in the employees' training logs. The training measures instituted will address and potential or current practices that may occur from the same deficient practice. Lake Owasso Residence (LOR) is not disputing the citation. However, LOR continues to assert that the investigation of this incident and the behaviors of the assessor calls into to question the application of an unbiased interview by a representative of MDH into this incident. hTe administrator or designee will report all allegations of abuse, neglect, maltreatment, mistreatment, injuries of unknown source, exploitation, involuntary seclusion, and misappropriation of property, elopement or missing persons from program to the administrator or designee and MAARC immediately. The operation program director is responsible for ensuring the implementation of reporting timeliness. DServices Director will compete quarterly audits to monitor for compliance.	1/8/2021

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	12/30/2020

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	The facility failed to identify and implement interventions to control and reduce the transmission of COVID-19 within 3 households (household 5, 7, and 8) with total of 16 clients, of which 7 were COVID-19 positive and 16 negative.	W406 SER	All staff will be retrained on these policy applications at the beginning of their next shift. Hand Washing/Disinfecting: Beginning 11/25/20, Services Director will initiate a hand-washing education program for all Residential Counselors concentrating first on those in the affected 3 houses referenced in this citation and continuing until all residential staff have completed the education. The in-service will include the use of a substance that temporarily stains the hands and requires thorough washing to eliminate to demonstrate the time and technique necessary to completely cleanse hands by washing. A competency test will be completed to demonstrate effective hand washing technique. The demonstration in-service will be conducted by or under the direction of the Services coordinator (may train others in how to conduct the training) and documented in the employees' training logs. The training measures instituted will address and potential or current practices that may occur from the same deficient practice. The program services team has been provide direction by the operations director to complete monitor for effective hand washing while on duty, effective 11/26/2020. Non-compliance to hand washing protocols when working with residents will result in a immediate coaching and correction. Infection control breaches will be recorded and reviewed as they occur to monitor adherence to practice and ensure the solution provided for improved infection control is effective. The records will be monitored for quality assurance.	12/2/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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[signature]	Administrator	12/30/2020

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	This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and implement interventions to control and reduce the transmission of COVID-19 within 3 households (household 5, 7, and 8) with total of 16 clients, of which 7 were COVID-19 positive and 16 negative.	W455 12/30/20 SER	All staff will be retrained on these policy applications at the beginning of their next shift. COVID-19 positive vs. negative residents in same house: a. Staff assignments changed 11/24/20 to assign one staff to attend to the needs of the COVID-19 positive clients and not work with the COVID-19 negative clients. Other staff are being assigned in the reverse (attend to negative but not positive clients) to reduce the risk of cross-contamination. (Currently 7 positive and 16 negative residents in 3 houses.) Cleaning/sanitizing protocol in the houses using approved Peroxide Multi Surface Cleanser will continue. b. Staff assigned to COVID-19 positive clients provided with multiple gowns so they can change between cares/soiling. Gloves, hand sanitizer, face shields and disposable masks in use. c. Staff assigned to COVID-19 positive clients will be given an information sheet with instructions on not providing any contact care to COVID-19 negative residents, but that if they must in the event of an urgent need, they should remove their gown and wash or sanitize hands prior to assisting the COVID-19 negative resident, then wash/sanitize hands and reapply a gown prior to returning to their assigned residents. The training measures instituted will address and potential or current practices that may occur from the same deficient practice. The program services team has been provide direction by the operations director to complete PPE compliance checks while on duty, effective 11/26/2020. Non-compliance to PPE requirements when working with residents will result in a immediate coaching and correction. PPE breaches will be recorded and reviewed as they occur to monitor adherence to practice and ensure the solution provided for improved infection control is effective. The breach logs will be monitored for quality assurance.	12/2/2020

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W 455	Continued From page 5	W 455		

form identified 3 houses with COVID-19 positive clients, house 5, 7 and 8. House 5 had one COVID positive client, house 7 had four COVID positive clients, and house 8 had two COVID positive clients.

On 11/24/20, at 8:15 a.m. the survey team entered into house 7 and noted residential counselor 1 (RC1)-A wearing a white isolation gown while standing in the kitchen. RC1-A was preparing breakfast for the clients in the house.

During interview on 11/24/20, at 8:20 a.m. RC1-A while wearing an isolation gown in the kitchen stated the staff have been instructed to place a gown on when they enter the house and to keep it on throughout their whole shift. Further, RC1-A stated the gown is only changed if it becomes soiled. When a gown becomes soiled the staff call down to the office and then someone will bring them another gown to use. Staff were assigned to care for all clients, whether they were positive for COVID-19 or not and were to wear the same gown to care for all clients.

During observation on 11/24/20, at 9:34 a.m. a COVID-19 positive client (C5) came from the bedroom and walked up to the kitchen counter where RC1-A was standing and placed an empty coffee cup on the counter. RC1-A did not redirect C5 to stay in their room even though C5 was COVID positive.

During observation in House 7 on 11/24/20, at 10:59 a.m. RC1-A entered C3's (identified as positive for COVID-19 on 11/16/20) room and provided peri-care and then dressed C3. During cares C3's clothing was touching RC1-A's isolation gown. After completing cares on C3,

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W 455	Continued From page 6 RC1-A removed gloves however, did not wash or sanitize hands. RC1-A went into the living room area and with the help of RC1-B transferred C4 (COVID-19 negative) from the wheelchair into the recliner. C4's clothing was touching the isolation gowns on both RC1-A and RC1-B. RCA-1 or RC1-B did not remove their gowns between clients who were COVID positive and COVID negative. Upon interview on 11/24/20, at 1:43 p.m. the administrator stated the staff in houses 5, 7, and 8, take care of COVID positive clients and COVID negative clients. Staff are only wearing one gown a day unless the gown is soiled then they are given another gown due to having a supply shortage. However, the County had supplied the facility with several shipments of extra supplies, including isolation gowns. Further, the administrator stated the staff should not wear the same gown between COVID negative and positive clients but was aware this was happening. The administrator reported this was occurring due to the fear of a major COVID outbreak and the potential to not have enough gowns with a new outbreak. The administrator stated this would be fixed immediately. The facility provided a policy titled COVID-19 Response Policy dated 6/23/20 and revised on 10/23/20, indicated staff wear gloves, isolation gowns, facemask, and eye protection when caring for residents with suspected or confirmed COVID-19. To minimize transmission risk, will assign dedicated staff to work with the individuals with COVID. There was no mention of using the same gown to care for COVID positive and COVID negative clients.	W 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G208	A. BUILDING _____ B. WING _____	C 11/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE OWASSO RESIDENCE	**210 OWASSO BLVD NORTH SHOREVIEW, MN 55126**

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W 455	Continued From page 7 The Centers for Disease Control (CDC) update on 10/9/20, identifies that extended use of isolation gowns can be worn by the same health care provider when interacting with more than one patient housed in the same location with the same known infectious disease, I.E. COVID-19 patients residing in an isolation cohort. Gowns should be worn for high contact patient care activities that provide opportunity for transfer of pathogens to other patients and staff via the soiled clothing of healthcare provider such as: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care. The CDC article dated 11/4/20, indicates the PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Reusable (i.e., washable or cloth) gowns should be laundered after each use. HAND HYGIENE: During observation on 11/24/20, at 9:03 a.m. RC1-A exited C4's room after starting a nebulizer, went to the kitchen sink, turned the water on, placed hands under the water, squirted soap onto hands and immediately placed hands under water, rubbed hands together and turned the faucet off with wet hands. RC1-A then grabbed paper towels, dried off hands, and threw paper towels in trash. RC1-A then proceeded to grab Styrofoam bowls and cups and placed them out	W 455		

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	24G208	A. BUILDING _____ B. WING _____	C 11/25/2020

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W 455	Continued From page 8	W 455		

on the counter.

During observation on 11/24/20, at 9:34 a.m. a COVID-19 positive client (C5) came from the bedroom and walked up to the kitchen counter and placed a coffee cup on the counter after finishing drinking the coffee. RC1-A grabbed the coffee cup with bare hands and placed cup into the sink. Afterwards, RC1-A turned the kitchen sink faucet on and rinsed both hands under the water without using soap, then RC1-A grabbed paper towels and dried off hands, turned the faucet off with the same paper towels, and threw the paper towels in the trash. RC1-A then reached into the refrigerator and grabbed out milk and juice, then proceeded to pour milk and juice into the cups on the counter.

During observation on 11/24/20, at 9:40 a.m. RC1-B came into the house after touching the doorknob and the kitchen counter then went to the kitchen sink. RC1-B turned on the faucet, placed hands under the water, placed soap on hands and immediately placed hands under the water and rubbed hands together for less than 10 seconds, grabbed paper towels and dried off hands, took the same paper towels and turned off the faucet, then placed paper towels in the trash. RC1-B then proceeded to help pour juice into cups on the counter.

During observation on 11/24/20, at 9:41 a.m. RC1-C went into the kitchen after touching the dining room table then turned the water on at the sink, placed hands under the water, applied soap then vigorously lathered soap for 5 seconds, placed hands under water and rubbed hands together for 5 seconds, turned faucet off, then grabbed paper towels and dried off hands, and

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	24G208	A. BUILDING _____ B. WING _____	C 11/25/2020

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W 455	Continued From page 9 threw paper towels in the trash. During interview on 11/24/20, at 9:48 a.m. RC1-A stated proper handwashing technique included turning on the water, washing hands with soap while scrubbing between fingers for 2 minutes, rinsing off hands, then getting paper towels to dry hands, and then using the same paper towels to shut off the faucet. Upon interview on 11/24/20, at 2:04 p.m. program director (PD)-A stated the proper technique for handwashing included staff washing hands vigorously for 20 seconds with soap, dry off hands with paper towels, and then use separate paper towels to turn off the faucet. PD-A stated the staff were sent a video to watch on proper handwashing technique. The facility provided a document titled "Handwashing: Clean Hands Save Lives, When and How to Wash Your Hands" by the Centers for Disease Control and Prevention (CDC) dated 10/14/20, indicated the proper technique to washing hands the staff would follow the following steps: 1) Wet hands with clean running water (warm or cold) and apply soap. 2) Lather hands by rubbing them together with the soap. Lather the backs of the hands, between the fingers, and under the nails. 3) Scrub the hands for at least 20 seconds. 4) Rinse hands under clean, running water. 5) Dry hands using a clean towel or air dry them. The IJ was removed on 11/25/20, at 4:36 p.m. when it was verified through observation, interview, and document review that the facility provided education and additional gowns for staff who provide care for COVID-19 positive clients.	W 455		

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LAKE OWASSO RESIDENCE	**210 OWASSO BLVD NORTH SHOREVIEW, MN 55126**

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W 455	Continued From page 10 Separate staff were assigned to COVID-19 positive and negative residents. In addition staff were retrained and re-educated on gown usage and handwashing, which included return demonstration. Measures were identified to monitor for compliance.	W 455		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed on December 15, 2020

Administrator
Lake Owasso Residence
210 Owasso Blvd North
Shoreview, MN 55126

Event ID: E6PP11

Dear Administrator:

The above facility was surveyed on November 23, 2020 through November 25, 2020 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule 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/RULES.

When all orders are corrected, the first page of the order form should be signed and returned to:

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Sue Reuss. A written plan for correction of licensing orders is not required.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me with any questions related to this letter.

Sincerely,

Amy Johnson

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121
Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00831	A. BUILDING: _____ B. WING _____	C 11/25/2020

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 11/23/20, 11/24/20 and 11/25/20 a surveyor of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of these orders for your records and return the original to the email address below: susanne.reuss@state.mn.us	5 000		

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5 655	MN Statute 144.651 Subd. 5. RES. RIGHTS Courteous treatment. Residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote dignity by speaking to a client in a person-centered, respectful manner for 1 of 5 clients (C1) who resided in the facility. Findings include: During initial observations on 11/23/20, at 10:31 a.m. designated support personnel (DSP)-1 stated to C1, "I don't know what you are waiting for C1, you know lunch is coming up and if you're sitting there still with breakfast, that's going to be a problem." DSP-1 then retrieved a brown piece of paper, took it over to C1 and attempted to have C1 sound out the word 'juice'. When C1 was unable to say it, DSP-1 stated in a rough and demanding voice, "see juice is on the list, so enough with the juice." DSP-1, with the same tone of voice, stated to C1, "if you are sitting there at lunch time that is your lunch. [C1] what are you doing, why are you staring at me". When interviewed on 11/23/20, at 2:09 p.m. DSP-1 reported his tone was not aggressive or demeaning to C1. When interviewed on 11/23/20, at 3:36 p.m. program director (PD)-1 was informed of the	5 655		

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5 655	Continued From page 2 above observation of DSP-1 to C1. PD-1 stated, "I would question [the staff] why they would say it like that" confirming the tone and language used was not person-centered. On 11/24/20, at 10:14 a.m. program supervisor (PM)-1 was also questioned on the DSP-1's comments and she confirmed the tone and language used was "inappropriate" referring to the comments made: "if you are sitting there at lunch time that is your lunch. [C1] what are you doing, why are you staring at me". The facilities' policy titled, Reporting of Maltreatment of Vulnerable Adults, last revised 9/30/20. Under section Definitions, defines Verbal Abuse: refers to any use of insulting, demeaning, disrespectful, oral, written or gestured language directed towards and in the presence of the resident. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 655		