DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

March 22, 2022

Administrator
Laura Baker Services Association
211 Oak Street
Northfield, MN 55057

RE: Event ID: VMNJ12

Dear Administrator:

On March 15, 2022, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

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February 9, 2022

Administrator
Laura Baker Services Association
211 Oak Street
Northfield, MN 55057

RE: Event ID: VMNJ11

Dear Administrator:

On January 20, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. This survey found 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 survey 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 electronically delivered "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy effective January 20, 2022.

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):

W406 42 CFR §483.470- Physical Environment

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).

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

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correctionk will be completed.

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 March 16, 2022, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

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
	24G500	A. BUILDING _____ B. WING _____	C 01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted from 1/14/22 - 1/20/22, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.475. The facility was in full compliance.	E 000		
W 000	INITIAL COMMENTS On 1/14/22 - 1/20/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. 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) Infection Control. The facility was not in compliance with deficiencies issued at W406 and W455. The following complaint was found to be UNSUBSTANTIATED: HG500094C (MN80125). The following complaint was found to be SUBSTANTIATED: HG500095C (MN79689) with no deficiency cited. The Condition of Participation: Physical Environment 42 CFR 483.470 was found not to be met. An Immediate Jeopardy (IJ) was identified at W455 on 1/14/22, at 5:30 p.m. The IJ began on 1/12/22, when the facility failed to follow CDC guidance for crisis staffing by not	W 000		

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

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W 000	Continued From page 1 reporting crisis staffing status to MDH or attempting to place other COVID negative staff in the home, prior to allowing 5 COVID positive staff to work and be quarantined to a home (COVID positive staff stayed in the home as "live in" staff) with 7 COVID negative clients from 1/12/22 - 1/17/22, resulting in 1 client (C3) testing positive for COVID. The administrator was informed of the IJ on 1/14/22, at 5:30 p.m. The immediate jeopardy was removed on 1/20/21, at 1:00 p.m. when the facility's approved removal plan was verified onsite by the state agency. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	W 000		
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: Based on observation, interview and document review, the Condition of Participation at 42 CFR 483.470, Physical Environment was not met. Findings include: See W455: The facility failed to implement appropriate PPE use for COVID positive staff and isolation precautions according to CDC guidance for 1 of 7 clients (C3) who were asymptomatic with a positive COVID test result. In addition, the facility failed to follow CDC and MDH guidance for	W 406		

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W 406	Continued From page 2 crisis staffing before allowing COVID positive staff to work with COVID negative clients. This resulted in an immediate jeopardy.	W 406		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the 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 implement appropriate Personal Protective Equipment (PPE) use for COVID positive staff and isolation precautions according to CDC guidance for 1 of 7 clients (C3) who was asymptomatic with a positive COVID test result. In addition, the facility failed to follow MDH guidance for crisis staffing before allowing COVID positive staff to work with COVID negative clients. This had the potential to affect all 7 residents (C11, C2, C3, C4, C5, C6, and C7) in the home. This resulted in an immediate jeopardy. The IJ began on 1/12/22, when the facility failed to follow CDD guidance for crisis staffing by not reporting crisis staffing status to MDH or attempting to place other COVID negative staff in the home, prior to allowing 5 COVID positive staff to work and be quarantined to a home (COVID positive staff stayed in the home as "live in" staff) with 7 COVID negative clients from 1/12/22 - 1/17/22, resulting in 1 client (C3) testing positive for COVID. The administrator was informed of the IJ on 1/14/22, at 5:30 p.m. The immediate jeopardy was removed on 1/20/21, at 1:00 p.m. when the facility's approved removal plan was verified onsite by the state agency.	W 455		

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W 455	Continued From page 3 Findings include: C1 face sheet reviewed 1/20/22, indicated C1's diagnosis included moderate intellectual disabilities. C2 face sheet reviewed 1/20/22, indicated C2's diagnosis included severe intellectual disabilities. C3 face sheet reviewed 1/20/22, indicated C3's diagnosis included bipolar disorder and profound intellectual disabilities and tested positive for COVID 19 on 1/14/22. C4 face sheet reviewed 1/20/22, indicated C4's diagnosis included autism and profound intellectual disabilities. C5 face sheet reviewed 1/20/22, indicated C5's diagnosis included moderate intellectual disabilities and autism. C6 face sheet reviewed 1/20/22, indicated C6's diagnosis included moderate intellectual disabilities and autism. C7 face sheet reviewed 1/20/22, indicated C7's diagnosis included Angelman syndrome (genetic disorder causing developmental disabilities). Employee and Staff Infectious Illness Log reviewed 1/14/22, indicated the following regarding staff COVID-19 status: 1) direct support professional (DSP)-A - tested positive on 1/7/22, was sent home, and returned to work on 1/12/22 where she quarantined in the home with the clients until 1/17/22. 2) DSP-B tested positive on 1/10/22, was sent home, returned to work on 1/12/22 where she quarantined in the home with the clients until 1/17/22. 3) DSP-C tested positive on 1/10/22, and was sent home where she continued to quarantine	W 455		

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W 455	Continued From page 4 and did not return work. 4) DSP-D tested positive on 1/12/22, where she quarantined in the home with the clients until 1/17/22. 5) House Manager (HM)- tested positive on 1/12/22, where she has quarantined in the home with the clients until 1/17/22. Facility COVID-19 test records indicated C1, C2, C3, C4, C5, C6, and C7 tested negative for COVID as of 1/8/22. All clients were fully vaccinated apart from C7 and all staff were documented as fully vaccinated. Facility Symptom Screening for COVID in staff and clients indicated missing data as follows: -C1 no screening completed from 1/2/22 - 1/12/22 and 1/19/22. -C2 no screening completed 1/2/22, 1/4/22,1/7/22, 1/9/22/ 1/11/22, 1/12/22 and 1/19/22. -C3 no screening completed 1/2/22, 1/4/22, 1/7/22, 1/9/22, 1/11/22, 1/12/22 and 1/19/22. -C4 vitals: no screening completed from 1/2/22 - 1/12/22 and 1/19/22. -C5 vitals no screening completed from 1/2/22 - 1/12/22 and 1/19/22. -C6 vitals no screening completed from 1/2/22 - 1/12/22 and 1/19/22. -C7 vitals: no screening completed 1/2/22, 1/4/22, 1/7/22, 1/9/22, 1/11/22, 1/12/22 and 1/19/22. -All client screenings from 1/13/22 - 1/18/22 included temperature but did not include other symptom screening. -No staff screening completed 1/2/22, 1/4/22, 1/5/22, 1/6/22, 1/7/22, 1/8/22, 1/9/22, 1/14/22, 1/19/22.	W 455		

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W 455	Continued From page 5 -All staff screenings from 1/13/22, 1/15/22, 1/16/22, 1/17/22, 1/18/22 included temperature but no symptom screening. On 1/14/22, at 12:29 p.m. DSP-B was in the living room within six feet (ft) of C7 who was unmasked. DSP-B had no eye protection in place and wore a surgical mask. DSP-B stated she cannot see the computer with the goggles on. At 12:35 p.m. mattresses were observed on the living room floor. DSP-B stated staff had been quarantined to the home with the client's 24/7 since 1/12/22, which included sleeping in the living room of the home. On 1/14/22, at 12:45 p.m. HM sat at the kitchen table less than six feet from C3 wearing a surgical mask and corrective lenses, with no eye protection in place. HM then removed her mask to eat lunch while C3 ate his lunch. DSP-A and DSP-B were also present and wore only surgical masks and protective eyewear. On 1/14/22, at 1:00 p.m. the qualified intellectual disability professional (QIDP)-A stated all staff should be wearing eye protection and N95's, gloves and gowns were only required during personal cares. QIDP-A stated none of the clients wore masks as they could not tolerate a mask. On 1/14/22, at 2:59 p.m. DSP-A and DSP-B sat in the living room and wore only surgical masks and eye protection. C1, C4, C5, and C7 sat and or moved about the living room coming within six feet of staff. At 3:00 p.m. QIDP-A entered the home wearing a surgical mask and eye protection on top of her head. At 3:12 p.m. DSP-A had not retrieved an N95 and continued to wear a surgical	W 455		

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W 455	Continued From page 6 mask. On 1/20/22, 11:01 a.m. a cleaning contractor was observed cleaning client rooms in the home wearing only a surgical mask and gloves, with no eye protection. When interviewed, the contractor indicated she was not informed there was a positive client in the home, or that specific PPE was required. When interviewed on 1/14/22, at 1:00 p.m. QIDP-A stated staff should wear eye protection and N95 masks when in the house and should also wear gowns and gloves during personal cares. QIDP-A stated the clients had all been assessed as unable to tolerate a mask and most were unable to remain in their rooms. QIDP-A stated staff members began testing positive on 1/8/22, and additional staff tested positive through 1/12/22, at which time the decision was made to quarantine the positive staff to the home with the clients as there were no other available staff to work. QIDP-A stated clients were also being quarantined to the home, without day programs or other outings, and being tested at 2 days after the 1/12/22 exposure began and 5 days after exposure using rapid tests. When interviewed on 1/14/22, at 1:30 p.m. the assistant program director (APM) verified all staff currently working in the home were positive for COVID and became quarantined to the home on 1/12/22 along with all seven clients. Clients were unable to attend day programs per day program policy due to exposure. APM verified the expectation for use of PPE was N95 masks, goggles, and gloves always in the home. APM verified C3 tested positive for COVID on 1/14/22.	W 455		

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W 455	Continued From page 7 When interviewed on 1/14/22, at 2:38 p.m. the program director (PD) verified positive staff were quarantined in the house 24/7 with the clients due to a staffing shortage. PD verified no clients were positive for COVID at the start of the quarantined on 1/12/22, and that C3 had become positive on 1/14/22. PD stated she was also out sick with COVID and APM was not trained to work with the clients. PD stated there were two additional staff who were not positive but could not work without supervision of a manager and were being scheduled at the other houses for staffing support. PD stated the QIDP's were assisting from the office with behavioral support but were not allowed to work the floor. PD stated the facility had access to a staffing agency, however bringing in staff who the clients were not familiar with posed a greater danger than COVID positive staff. PD verified clients were quarantined to the home and not allowed to attend programming. PD stated staff should be wearing full PPE which included gowns, gloves, N95's, and goggles, at all times. PD stated no additional staff would be brought into the house until the COVID positive staff were past their quarantine period. When interviewed on 1/14/22, at 3:03 p.m. DSP-B verified she should always wear a mask and eye protection, and gloves when providing direct care. DSP-B stated she was wearing an N95 mask earlier, but it recently broke, and she would need to get a new one from the staff office. When interviewed on 1/14/22, at 3:05 p.m. DSP-D verified she should wear a mask, eye protection, gown, and gloves. DSP-D states she did not wear goggles due to wearing her prescription glasses, she did not wear gowns as they were too long for her, and she did not wear	W 455		

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W 455	Continued From page 8	W 455		

gloves because they made her hands sweaty. DSP-B and DSP-C stated they volunteered to quarantine at the home.

When interviewed on 1/14/22, at 3:10 p.m. HM verified she was wearing a surgical mask during her shift and stated it was because she was the 1:1 staff for C3, who had already tested positive for COVID.

When interviewed on 1/18/22, at 9:45 p.m. APM stated the facility did not reach out to MDH to report the positive staff cases, as she believed the MDH long term care call on 1/12/22, directed facilities did not need to report staff cases to MDH any longer, and the redcap report form no longer accepts them. APM verified the facility did not reach out to staffing crisis center prior to using COVID positive staff per guidance. APM verified members of management including herself, and QIDP staff were not scheduled to work at the home or directly with clients, despite being on the facility grounds and reporting availability.

When interviewed on 1/18/22, 11:50 a.m. APM verified missing COVID screenings for clients and staff and stated two houses merged in December which may have resulted in some missing data at that time but could not explain missing data for January.

When interviewed on 1/18/22, at 12:23 p.m. PD verified missing COVID screenings for clients and staff, and stated a daily symptom screening should be completed for staff and clients in addition to adding client temperatures being logged in Therap (Electronic Documentation System).

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W 455	Continued From page 9 When interviewed on 1/20/22, at 11:18 a.m. the PD stated contractors were required to wear full PPE while in the home. Facility policy titled Infection Control dated 2/16, indicated surveillance procedures included maintain an infection control log to document all diagnosed incidences of communicable disease or infestation. A report to the local health authority must be made if the diseases listed under Reportable Diseases are reported or observed in individuals, volunteers, or staff members. This report must be submitted within 24 hours. Any staff member with a communicable disease will not be permitted to work in the facility until such time that a physician certifies that the staff member's condition will permit a return to work without endangering the health of other staff and individuals. Facility policy titled Laura Baker Services Association COVID-19 Preparedness Plan dated 1/5/21, contained outdated COVID-19 recommendations for healthcare workers dated 12/18/20. The policy contained outdated information on restricting visitors including limiting the number of visitors, physical contact, and time constraints on visit, the policy contained no language about placing positive residents on quarantine utilizing contact precautions and contained no direction for use of N95 masks while working with residents who were positive for COVID-19. Facility policy titled 3.6. Emergency Staffing and Use of Volunteers, undated, indicated in an emergent situation that impacts the availability of staff, we will use a variety of emergency staffing strategies, including but not necessarily limited to	W 455		

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W 455	Continued From page 10 the following: 1. call back staff who may have been quarantined (if for public health emergency), contact staff who are infrequent or seasonal, and contact former staff to determine availability. 2. reach out to related facilities or partners for staffing support. 3. identify administrative or other staff receive "just in time" training to provide direct support. 4. contact staffing agencies for assistance. sign a contract with at least one, preferably more. 5. ask what the ability is for these agencies to provide last minute coverage. check on how this availability changes during the crisis. 6. refer to list on the MDH health care provider directory at: 7. reach out to organizations with which LBSA has entered a memorandum of understanding (mou) as part of emergency preparedness planning. 8. contact rice county public health for county-level assistance. 9. contact regional health care preparedness coordinator (rhpc) and health care coalition for regional level assistance. Possible regional resources could include red cross, volunteer organization active in disaster, and the medical reserve corps. 10. engage provider associations to assist in procuring staff. 11. if all the above have been exhausted, contact Minnesota healthcare resource call center at 1-833-454-0149 or 651-201-3970 (local) for crisis management. have specific information about open shifts for the next 48 hours at crisis levels. The MDH Weekly LTC COVID-19 Call notes dated 1/12/22, directed if on site SARS CoV 2 testing is done by your facility (such as rapid	W 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G500	A. BUILDING _____ B. WING _____	C 01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

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W 455	Continued From page 11 antigen or rapid molecular tests), all positive and negative results in staff and residents must be submitted through RePortal. Facility policy titled Laura Baker Services Association COVID-19 Preparedness Plan dated 1/19/22, indicated when working with a client with a confirmed or suspected case of COVID-19, staff are required to wear full personal protective equipment (PPE) in accordance with CDC and MPH guidance, including an N95 or higher-level respirator, eye protection, gloves, and gown. In LBSA residences, staff must complete a daily assessment of symptoms at the commencement of their shift, including taking their temperature. If staff exhibit one or more symptoms, they must immediately contact a supervisor and will be asked to leave work if ill. Staff will be asked to be tested for COVID-19 if warranted. Rapid antigen testing kits are available in the houses or from the health office. Depending on the outcome of testing, staff may be required to be out of work per the guidelines established by CDC/MDH for either quarantine or isolation: This information is maintained in a log that is kept on the residence. Staff must assess clients for COVID-19 symptoms at least once per day. LBSA will report positive cases and any other test results required by MDH and will follow their directives. The immediate jeopardy that began on 1/12/22, was removed on 1/20/22, when an onsite visit verified through interview, observation and record review the facility conducted training for all staff on appropriate PPE use and isolation/quarantine practices, the facility contacted MDH to get approval for the use of emergency staffing, testing and screening was implemented per guidance and a plan was developed and	W 455		

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W 455	Continued From page 12 implemented to phase out COVID positive staff working with COVID negative clients.	W 455		

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	01163	A. BUILDING: _____ B. WING _____	C 01/20/2022

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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 1/14/22 - 1/20/22, a complaint investigation was conducted. Your facility was found to be in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaint was found to be UNSUBSTANTIATED: HG500094C (MN80125). The following complaint was found to be SUBSTANTIATED: HG500095C (MN79689) with	5 000		

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5 000	Continued From page 1 no licensing orders issued.	5 000		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 9, 2022

Administrator
Laura Baker Services Association
211 Oak Street
Northfield, MN 55057

Re: Project Number Event ID: VMNJ11

Dear Administrator:

The above facility survey was completed on January 20, 2022 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted from 1/14/22 - 1/20/22, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.475. The facility was in full compliance.	E 000	Susie Haven reviewed and approved 3/4/22	
W 000	INITIAL COMMENTS On 1/14/22 - 1/20/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. 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) Infection Control. The facility was not in compliance with deficiencies issued at W406 and W455. The following complaint was found to be UNSUBSTANTIATED: HG500094C (MN80125). The following complaint was found to be SUBSTANTIATED: HG500095C (MN79689) with no deficiency cited. The Condition of Participation: Physical Environment 42 CFR 483.470 was found not to be met. An Immediate Jeopardy (IJ) was identified at W455 on 1/14/22, at 5:30 p.m. The IJ began on 1/12/22, when the facility failed to follow CDC guidance for crisis staffing by not	W 000	Household directors will complete a staff observation for all clients to assure current PPE useage. (this covers the clients piece). Facility administrator is responsible to assure completion. All staff will be trained on proper PPE useage for different situations by the household directors. Facility administrator is responsible to assure completion. PPE will be added to the current staff observation checklist. Household Directors complete the staff observation checklist 1x weekly, QDDP's complete staff observation checklist 1x monthly. facility administraor is responsible to assure completion. All staff observation checklists will be turned in to the facility admiistrator to assure continued completion.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Laudont	Facility Aministrator	2/28/22

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 reporting crisis staffing status to MDH or attempting to place other COVID negative staff in the home, prior to allowing 5 COVID positive staff to work and be quarantined to a home (COVID positive staff stayed in the home as "live in" staff) with 7 COVID negative clients from 1/12/22 - 1/17/22, resulting in 1 client (C3) testing positive for COVID. The administrator was informed of the IJ on 1/14/22, at 5:30 p.m. The immediate jeopardy was removed on 1/20/21, at 1:00 p.m. when the facility's approved removal plan was verified onsite by the state agency. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	W 000		
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: Based on observation, interview and document review, the Condition of Participation at 42 CFR 483.470, Physical Environment was not met. Findings include: See W455: The facility failed to implement appropriate PPE use for COVID positive staff and isolation precautions according to CDC guidance for 1 of 7 clients (C3) who were asymptomatic with a positive COVID test result. In addition, the facility failed to follow CDC and MDH guidance for	W 406	W406 Household directors will complete a staff observation for all clients to assure current PPE useage. (this covers the clients piece). Facility administrator is responsible to assure completion. All staff will be trained on proper PPE useage for different situations by the household directors. Facility administrator is responsible to assure completion. PPE will be added to the current staff observation checklist. Household Directors complete the staff observation checklist 1x weekly, QDDP's complete staff observation checklist 1x monthly. facility administraor is responsible to assure completion. All staff observation checklists will be turned in to the facility admiistrator to assure continued completion. covid policy will be updated to include links to guidance to stay current. facility aministrator is to assure completion.	2/15/22

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W 406	Continued From page 2 crisis staffing before allowing COVID positive staff to work with COVID negative clients. This resulted in an immediate jeopardy.	W 406		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the 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 implement appropriate Personal Protective Equipment (PPE) use for COVID positive staff and isolation precautions according to CDC guidance for 1 of 7 clients (C3) who was asymptomatic with a positive COVID test result. In addition, the facility failed to follow MDH guidance for crisis staffing before allowing COVID positive staff to work with COVID negative clients. This had the potential to affect all 7 residents (C11, C2, C3, C4, C5, C6, and C7) in the home. This resulted in an immediate jeopardy. The IJ began on 1/12/22, when the facility failed to follow CDD guidance for crisis staffing by not reporting crisis staffing status to MDH or attempting to place other COVID negative staff in the home, prior to allowing 5 COVID positive staff to work and be quarantined to a home (COVID positive staff stayed in the home as "live in" staff) with 7 COVID negative clients from 1/12/22 - 1/17/22, resulting in 1 client (C3) testing positive for COVID. The administrator was informed of the IJ on 1/14/22, at 5:30 p.m. The immediate jeopardy was removed on 1/20/21, at 1:00 p.m. when the facility's approved removal plan was verified onsite by the state agency.	W 455	see W 406	

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W 455	Continued From page 3 Findings include: C1 face sheet reviewed 1/20/22, indicated C1's diagnosis included moderate intellectual disabilities. C2 face sheet reviewed 1/20/22, indicated C2's diagnosis included severe intellectual disabilities. C3 face sheet reviewed 1/20/22, indicated C3's diagnosis included bipolar disorder and profound intellectual disabilities and tested positive for COVID 19 on 1/14/22. C4 face sheet reviewed 1/20/22, indicated C4's diagnosis included autism and profound intellectual disabilities. C5 face sheet reviewed 1/20/22, indicated C5's diagnosis included moderate intellectual disabilities and autism. C6 face sheet reviewed 1/20/22, indicated C6's diagnosis included moderate intellectual disabilities and autism. C7 face sheet reviewed 1/20/22, indicated C7's diagnosis included Angelman syndrome (genetic disorder causing developmental disabilities). Employee and Staff Infectious Illness Log reviewed 1/14/22, indicated the following regarding staff COVID-19 status: 1) direct support professional (DSP)-A - tested positive on 1/7/22, was sent home, and returned to work on 1/12/22 where she quarantined in the home with the clients until 1/17/22. 2) DSP-B tested positive on 1/10/22, was sent home, returned to work on 1/12/22 where she quarantined in the home with the clients until 1/17/22. 3) DSP-C tested positive on 1/10/22, and was sent home where she continued to quarantine	W 455		

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W 455	Continued From page 4 and did not return work. 4) DSP-D tested positive on 1/12/22, where she quarantined in the home with the clients until 1/17/22. 5) House Manager (HM)- tested positive on 1/12/22, where she has quarantined in the home with the clients until 1/17/22. Facility COVID-19 test records indicated C1, C2, C3, C4, C5, C6, and C7 tested negative for COVID as of 1/8/22. All clients were fully vaccinated apart from C7 and all staff were documented as fully vaccinated. Facility Symptom Screening for COVID in staff and clients indicated missing data as follows: -C1 no screening completed from 1/2/22 - 1/12/22 and 1/19/22. -C2 no screening completed 1/2/22, 1/4/22,1/7/22, 1/9/22/ 1/11/22, 1/12/22 and 1/19/22. -C3 no screening completed 1/2/22, 1/4/22, 1/7/22, 1/9/22, 1/11/22, 1/12/22 and 1/19/22. -C4 vitals: no screening completed from 1/2/22 - 1/12/22 and 1/19/22. -C5 vitals no screening completed from 1/2/22 - 1/12/22 and 1/19/22. -C6 vitals no screening completed from 1/2/22 - 1/12/22 and 1/19/22. -C7 vitals: no screening completed 1/2/22, 1/4/22, 1/7/22, 1/9/22, 1/11/22, 1/12/22 and 1/19/22. -All client screenings from 1/13/22 - 1/18/22 included temperature but did not include other symptom screening. -No staff screening completed 1/2/22, 1/4/22, 1/5/22, 1/6/22, 1/7/22, 1/8/22, 1/9/22, 1/14/22, 1/19/22.	W 455		

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W 455	Continued From page 5 -All staff screenings from 1/13/22, 1/15/22, 1/16/22, 1/17/22, 1/18/22 included temperature but no symptom screening. On 1/14/22, at 12:29 p.m. DSP-B was in the living room within six feet (ft) of C7 who was unmasked. DSP-B had no eye protection in place and wore a surgical mask. DSP-B stated she cannot see the computer with the goggles on. At 12:35 p.m. mattresses were observed on the living room floor. DSP-B stated staff had been quarantined to the home with the client's 24/7 since 1/12/22, which included sleeping in the living room of the home. On 1/14/22, at 12:45 p.m. HM sat at the kitchen table less than six feet from C3 wearing a surgical mask and corrective lenses, with no eye protection in place. HM then removed her mask to eat lunch while C3 ate his lunch. DSP-A and DSP-B were also present and wore only surgical masks and protective eyewear. On 1/14/22, at 1:00 p.m. the qualified intellectual disability professional (QIDP)-A stated all staff should be wearing eye protection and N95's, gloves and gowns were only required during personal cares. QIDP-A stated none of the clients wore masks as they could not tolerate a mask. On 1/14/22, at 2:59 p.m. DSP-A and DSP-B sat in the living room and wore only surgical masks and eye protection. C1, C4, C5, and C7 sat and or moved about the living room coming within six feet of staff. At 3:00 p.m. QIDP-A entered the home wearing a surgical mask and eye protection on top of her head. At 3:12 p.m. DSP-A had not retrieved an N95 and continued to wear a surgical	W 455		

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W 455	Continued From page 6 mask. On 1/20/22, 11:01 a.m. a cleaning contractor was observed cleaning client rooms in the home wearing only a surgical mask and gloves, with no eye protection. When interviewed, the contractor indicated she was not informed there was a positive client in the home, or that specific PPE was required. When interviewed on 1/14/22, at 1:00 p.m. QIDP-A stated staff should wear eye protection and N95 masks when in the house and should also wear gowns and gloves during personal cares. QIDP-A stated the clients had all been assessed as unable to tolerate a mask and most were unable to remain in their rooms. QIDP-A stated staff members began testing positive on 1/8/22, and additional staff tested positive through 1/12/22, at which time the decision was made to quarantine the positive staff to the home with the clients as there were no other available staff to work. QIDP-A stated clients were also being quarantined to the home, without day programs or other outings, and being tested at 2 days after the 1/12/22 exposure began and 5 days after exposure using rapid tests. When interviewed on 1/14/22, at 1:30 p.m. the assistant program director (APM) verified all staff currently working in the home were positive for COVID and became quarantined to the home on 1/12/22 along with all seven clients. Clients were unable to attend day programs per day program policy due to exposure. APM verified the expectation for use of PPE was N95 masks, goggles, and gloves always in the home. APM verified C3 tested positive for COVID on 1/14/22.	W 455		

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W 455	Continued From page 7 When interviewed on 1/14/22, at 2:38 p.m. the program director (PD) verified positive staff were quarantined in the house 24/7 with the clients due to a staffing shortage. PD verified no clients were positive for COVID at the start of the quarantined on 1/12/22, and that C3 had become positive on 1/14/22. PD stated she was also out sick with COVID and APM was not trained to work with the clients. PD stated there were two additional staff who were not positive but could not work without supervision of a manager and were being scheduled at the other houses for staffing support. PD stated the QIDP's were assisting from the office with behavioral support but were not allowed to work the floor. PD stated the facility had access to a staffing agency, however bringing in staff who the clients were not familiar with posed a greater danger than COVID positive staff. PD verified clients were quarantined to the home and not allowed to attend programming. PD stated staff should be wearing full PPE which included gowns, gloves, N95's, and goggles, at all times. PD stated no additional staff would be brought into the house until the COVID positive staff were past their quarantine period. When interviewed on 1/14/22, at 3:03 p.m. DSP-B verified she should always wear a mask and eye protection, and gloves when providing direct care. DSP-B stated she was wearing an N95 mask earlier, but it recently broke, and she would need to get a new one from the staff office. When interviewed on 1/14/22, at 3:05 p.m. DSP-D verified she should wear a mask, eye protection, gown, and gloves. DSP-D states she did not wear goggles due to wearing her prescription glasses, she did not wear gowns as they were too long for her, and she did not wear	W 455		

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	24G500	A. BUILDING _____ B. WING _____	C 01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA BAKER SERVICES ASSOCIATION	211 OAK STREET NORTHFIELD, MN 55057

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W 455	Continued From page 8	W 455		

gloves because they made her hands sweaty. DSP-B and DSP-C stated they volunteered to quarantine at the home.

When interviewed on 1/14/22, at 3:10 p.m. HM verified she was wearing a surgical mask during her shift and stated it was because she was the 1:1 staff for C3, who had already tested positive for COVID.

When interviewed on 1/18/22, at 9:45 p.m. APM stated the facility did not reach out to MDH to report the positive staff cases, as she believed the MDH long term care call on 1/12/22, directed facilities did not need to report staff cases to MDH any longer, and the redcap report form no longer accepts them. APM verified the facility did not reach out to staffing crisis center prior to using COVID positive staff per guidance. APM verified members of management including herself, and QIDP staff were not scheduled to work at the home or directly with clients, despite being on the facility grounds and reporting availability.

When interviewed on 1/18/22, 11:50 a.m. APM verified missing COVID screenings for clients and staff and stated two houses merged in December which may have resulted in some missing data at that time but could not explain missing data for January.

When interviewed on 1/18/22, at 12:23 p.m. PD verified missing COVID screenings for clients and staff, and stated a daily symptom screening should be completed for staff and clients in addition to adding client temperatures being logged in Therap (Electronic Documentation System).

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W 455	Continued From page 9 When interviewed on 1/20/22, at 11:18 a.m. the PD stated contractors were required to wear full PPE while in the home. Facility policy titled Infection Control dated 2/16, indicated surveillance procedures included maintain an infection control log to document all diagnosed incidences of communicable disease or infestation. A report to the local health authority must be made if the diseases listed under Reportable Diseases are reported or observed in individuals, volunteers, or staff members. This report must be submitted within 24 hours. Any staff member with a communicable disease will not be permitted to work in the facility until such time that a physician certifies that the staff member's condition will permit a return to work without endangering the health of other staff and individuals. Facility policy titled Laura Baker Services Association COVID-19 Preparedness Plan dated 1/5/21, contained outdated COVID-19 recommendations for healthcare workers dated 12/18/20. The policy contained outdated information on restricting visitors including limiting the number of visitors, physical contact, and time constraints on visit, the policy contained no language about placing positive residents on quarantine utilizing contact precautions and contained no direction for use of N95 masks while working with residents who were positive for COVID-19. Facility policy titled 3.6. Emergency Staffing and Use of Volunteers, undated, indicated in an emergent situation that impacts the availability of staff, we will use a variety of emergency staffing strategies, including but not necessarily limited to	W 455		

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W 455	Continued From page 10 the following: 1. call back staff who may have been quarantined (if for public health emergency), contact staff who are infrequent or seasonal, and contact former staff to determine availability. 2. reach out to related facilities or partners for staffing support. 3. identify administrative or other staff receive "just in time" training to provide direct support. 4. contact staffing agencies for assistance. sign a contract with at least one, preferably more. 5. ask what the ability is for these agencies to provide last minute coverage. check on how this availability changes during the crisis. 6. refer to list on the MDH health care provider directory at: 7. reach out to organizations with which LBSA has entered a memorandum of understanding (mou) as part of emergency preparedness planning. 8. contact rice county public health for county-level assistance. 9. contact regional health care preparedness coordinator (rhpc) and health care coalition for regional level assistance. Possible regional resources could include red cross, volunteer organization active in disaster, and the medical reserve corps. 10. engage provider associations to assist in procuring staff. 11. if all the above have been exhausted, contact Minnesota healthcare resource call center at 1-833-454-0149 or 651-201-3970 (local) for crisis management. have specific information about open shifts for the next 48 hours at crisis levels. The MDH Weekly LTC COVID-19 Call notes dated 1/12/22, directed if on site SARS CoV 2 testing is done by your facility (such as rapid	W 455		

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W 455	Continued From page 11 antigen or rapid molecular tests), all positive and negative results in staff and residents must be submitted through RePortal. Facility policy titled Laura Baker Services Association COVID-19 Preparedness Plan dated 1/19/22, indicated when working with a client with a confirmed or suspected case of COVID-19, staff are required to wear full personal protective equipment (PPE) in accordance with CDC and MPH guidance, including an N95 or higher-level respirator, eye protection, gloves, and gown. In LBSA residences, staff must complete a daily assessment of symptoms at the commencement of their shift, including taking their temperature. If staff exhibit one or more symptoms, they must immediately contact a supervisor and will be asked to leave work if ill. Staff will be asked to be tested for COVID-19 if warranted. Rapid antigen testing kits are available in the houses or from the health office. Depending on the outcome of testing, staff may be required to be out of work per the guidelines established by CDC/MDH for either quarantine or isolation: This information is maintained in a log that is kept on the residence. Staff must assess clients for COVID-19 symptoms at least once per day. LBSA will report positive cases and any other test results required by MDH and will follow their directives. The immediate jeopardy that began on 1/12/22, was removed on 1/20/22, when an onsite visit verified through interview, observation and record review the facility conducted training for all staff on appropriate PPE use and isolation/quarantine practices, the facility contacted MDH to get approval for the use of emergency staffing, testing and screening was implemented per guidance and a plan was developed and	W 455		

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W 455	Continued From page 12 implemented to phase out COVID positive staff working with COVID negative clients.	W 455		