Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

November 2, 2022

Administrator
Axis On White Bear Avenue
3516 White Bear Avenue
White Bear Lake, MN 55110

RE: Event ID: CBNY12

Dear Administrator:

On October 25, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

November 2, 2022

Administrator
Axis On White Bear Avenue
3516 White Bear Avenue
White Bear Lake, MN 55110

Re: Enclosed Re-inspection Results - Event ID: CBNY11

Dear Administrator:

On October 25, 2022 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a re-inspection of your facility, to determine correction of orders found on the survey completed on September 1, 2022 with orders received by you on September 15, 2022. At this time these correction orders were found corrected.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

September 15, 2022

Administrator
Axis On White Bear Avenue
3516 White Bear Avenue
White Bear Lake, MN 55110

RE: Event ID: CBNY11

Dear Administrator:

On September 1, 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 August 26, 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):

W318 42 CFR § 483.460 - Health Care Services
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 October 26, 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.

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G505	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIS ON WHITE BEAR AVENUE	3516 WHITE BEAR AVENUE WHITE BEAR LAKE, MN 55110

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health on 8/31/22, to determine compliance with Emergency Preparedness regulations §483.475. The facility was in full compliance.	E 000	Susie Haben received 10/19/22 approved 10/19/22 POC date 10/22/22	
W 000	INITIAL COMMENTS On 8/25/22-9/01/22, 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 SUBSTANTIATED: HG5054274C (MN86084) with deficiency cited at W318 and W331. The Condition of Participation: Health Care Services 42 CFR 483.460 was found not met with deficiency cited at W331. 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 8/26/22, at 4:55 p.m. The IJ began on 8/19/22, when the facility failed	W 000		

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

Anne M. Cade Program Compliance Specialist 10/19/22

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 to follow CDC 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 2 COVID positive staff to work with COVID negative clients from 8/19/22-8/30/22, two clients tested positive for COVID on 8/25/22, (C2 and C3) and a third on 8/27/22 (5). The administrator was informed of the IJ on 8/26/22, at 4:45 p.m. The immediate jeopardy was removed on 8/31/22, at 4:41 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 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.460 Health Care Services, was not met when the facility failed to clarify and implement physician's orders to ensure adequate nursing care. Findings include: See W331: Facility failed to ensure nursing services were implemented for following physician orders and plan of care for 1 of 1 client (C1) who had a seizure disorder and was	W 318	W 318: Health care services. The plan of correction for this deficiency is fully incorporated into the plan of correction for deficiency W331.	

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W 318	Continued From page 2 hospitalized and expired. In addition, the facility failed to clarify physician orders for 1 of 1 clients (C2) who had a suprapubic catheter which was not irrigated and received a urinary tract infection (UTI) and was hospitalized.	W 318	W331: nursing services: The standard was not met as evidenced by comments made by LPN-A, RN from C1's neurology clinic, review of physician's orders and interview with RN-C. The failure to meet the standard was revealed during survey conducted at the facility starting on 8/25/2022. To correct this deficiency, all direct support staff will receive training from a licensed nurse regarding the implementation of physician orders. This retraining will occur on or before October 21, 2022. As part of the retraining, nightly checks will be performed by direct support staff, as directed by the individual's program plan. The program supervisor will monitor the implementation of this change. This change to program plan implementation will begin immediately. Additionally, the program supervisor and direct support staff will ensure that any information from the day program will be incorporated into the client's documentation and acted upon. The Program supervisor will monitor any follow up appointments directed by a medical professional. With regard to any chronic living conditions including seizure disorders, feeding tubes, catheters, and other conditions requiring frequent	10/21/22
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nursing services were implemented related to following physician orders and plan of care for 1 of 1 client (C1) who had a seizure disorder and was hospitalized and expired. In addition, the facility failed to clarify physician orders for 1 of 1 clients (C2) who had a suprapubic catheter which was not irrigated and received a urinary tract infection (UTI) and was hospitalized. Findings include: C1's Face Sheet undated, indicated C1 had severe intellectual disabilities, seizure disorder, vagus nerve stimulator VNS (used to treat epilepsy) and cerebral palsy. C1's Care Plan dated 2/21/22, indicated he can not cry out loud if needed, required staff to use a lift to transfer, can reposition in bed, used wheelchair with history of seizures. The care plan further indicated staff were to check C1 every two hours and assist him with freshening up as needed. In addition the care plan indicated he had diagnosis of Epilepsy and seizure disorder.	W 331		

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W 331	Continued From page 3 An Internal Reporting and Investigation dated 8/18/22, at 5:00 a.m. indicated direct support professional (DSP)-B completed his nightly checks with C1 at 12:00 a.m. and 2:00 a.m. and C1 was found sleeping with no concerns. DSP-B went to get C1 up for the day at 5:00 a.m. and C1 was noticed to be cold to the touch and had foam around his mouth. DSP-B checked for pulse called 911 and performed CPR. During interview on 8/25/22, at 4:00 p.m. DSP-B stated he worked the night shift with C1 on 8/18/22, and completed his usual checks at 12:00 a.m., 2:00 a.m. and went to get him up at 5:00 a.m. and found him not breathing, had foam around his mouth and called 911 and started CPR. The paramedics arrived and the medical examiner removed his body since he passed away. A Coroner's report was requested but not received. Seizures Review of C1's Seizures and hospitalizations indicated the following: On 2/3/22, had seizure and went to emergency department (ED) and diagnosed with urinary tract infection (UTI). On 3/6/22, had 2 minute seizure, went to ED. On 4/27/22, had a 2 minute seizure at 11:50 a.m., used VNS magnet and came out of seizure 30 seconds (NO ER Visit DOCUMENTED). On 5/13/22, had a 2 minute seizure around 12:30 p.m., used VNS magnet, effective. On 5/16/22, had 1 min seizure and 30 seconds,	W 331	monitoring, follow up appointments will be scheduled the day of any routine appointments, as directed by the doctor treating the chronic living condition or their staff. The program supervisor will monitor. Axis will add to return from hospital visit form a request to the medical professional to address any after care orders. Program supervisor will monitor. This deficiency will be corrected on October 21, 2022. The plan of correction will be fully implemented and in place on or before October 21, 2022.	

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W 331	Continued From page 4 VNS magnet worked, stopped seizure with in 20 seconds. On 6/18/22, had seizure, went to ED. Went to follow up neurologist on 6/29/22, seizure medication increased. On 7/12/22, had seizure, went to ED. After Visit Summary dated 7/12/22, indicated to schedule an appointment with neurology as soon as possible for a visit. Record review and interview with the clinic indicated the appointment was not scheduled until 8/11/22, by the HS for 9/9/22. (Almost 2 months later). On 7/24/22, had seizure went to ED. After Visit Summary on 7/24/22, indicated C1 was to be seen by primary physician as soon as possible. Record review lacked evidence this appointment was scheduled. On 8/1/22, seizure at day program noted, review of facility records lacked details and documentation of this seizure (type of seizure, time, length, if VNS magnet was administered). On 8/2/22, seizure at day program noted, review of facility records lacked details and documentation of this seizure (type of seizure, time, length, if VNS magnet was administered). On 8/5/22, seizure at day program went to ED, review of facility records lacked details and documentation of this seizure. On 8/8/22, seizure at day program went to ED, review of facility records lacked details and documentation of this seizure. On 8/15/22, seizure at day program noted, review of facility records lacked details and documentation of this seizure (type of seizure, time, length, if VNS magnet was administered). On 8/17/22, seizure at day program noted, review of facility records lacked details and documentation of this seizure (type of seizure, time, length, if VNS magnet was administered).	W 331		

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W 331	Continued From page 5 During interview on 8/25/22, at 10:08 a.m. facility licensed practical nurse (LPN)-A stated the day program should be informing us when C1 had seizures while there. LPN stated he was unable to locate documentation of C1 having seizures at the day program but knows he has had several seizures there. LPN-A added, we were aware of some of the seizures because C1 was sent to the ED during some a few of the seizures but not all, whether the day program contacted us or not is hard to tell because our records do not indicated either way. During interview on 8/25/22, at 11:00 a.m. HS stated she was unable to find documentation of C1's seizures at the day program and there should be documentation in the chart. In addition, the HS stated she did make C1's appointment to be seen by the neurologist and does not recall why it was made late and missed making a follow up appointment for C1 to be seen for a follow up visit with primary physician. During interview on 8/25/22, at 4:26 p.m. receptionist from Minnesota Epilepsy Group stated they received a call from the HS on 8/11/22, appointment was made for C1 to be seen on 9/9/22. The receptionist stated when client's receive orders from the hospital or ED visits to be seen, they do save special spots for clients to be soon sooner if requested. The receptionist stated she did not see any request for C1 to be seen sooner. During interview 8/29/22, at 11:39 a.m. registered nurse (RN)-B from C1's neurology clinic stated C1 had a severe form of epilepsy and did expect to be informed of all ED visits related to a seizure.	W 331		

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W 331	Continued From page 6 RN-B stated in review of records with surveyor, it appeared they were not informed of the ED visit on 8/5/22 and should have been. Additionally, RN-B stated even though C1 did miss an appointment the ED wanted scheduled back in July of 2022, the doctor did not feel this would have prevented him from his passing as he was evaluated in the ED several times before and had medication changes leading up to what was believed to be his final seizure (though no official cause of death had been released). C2's Face Sheet undated indicated he had diagnosis of severe intellectual disabilities, history of urinary tract infections and had suprapubic catheter. C2's Physician orders dated 6/16/22, indicated C1 had 18 french (FR) Foley catheter, irrigate catheter weekly, instill 60 milliliters (ML) of saline, gently withdraw the saline, look for mucus debris, discard saline, repeat until clear. A Referral Form dated 5/5/22, from urology indicated C1 will have a suprapubic catheter insertion. Attached with the referral indicated patient education instructions which included Suprapubic Catheter Care. The instructions indicated to complete weekly, irrigation of the catheter. A Referral Form dated 8/8/22, indicated C1 had a suprapubic tube inserted. The referral indicated under follow up: Change tube 6 weeks at Gillette Clinic-Life time. During observation and interview on 8/25/22, at 12:00 p.m. C1 was observed to be sitting by the kitchen table with a leg bag attached to his	W 331		

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W 331	Continued From page 7 suprapubic catheter. C1's urine was dark yellow in color. LPN stated C1 recently had a suprapubic catheter placed due to increased UTI's and they are trying to have him increase his fluid intake. During interview on 9/1/22, LPN stated when C1 returned from having his suprapubic catheter placed he discontinued his previous weekly catheter irrigations since he thought you would not irrigate a suprapubic catheter. During interview on 8/30/22, at 11:45 a.m. HS stated C1 was admitted to the hospital on 8/29/22, with diagnosis of UTI and bowel obstruction. During interview on 9/1/22, at 2:30 p.m. urologists nurse registered nurse (RN)-C stated after a newly placed suprapubic catheter placement you should not irrigate for the first 14 days and then irrigations should resume. RN-C stated C1 should have had his catheter irrigated on 8/22/22. The RN did stated C1 might have already had the UTI and was uncertain if that was the cause of his hospitalization. During interview 9/1/22, at 2:45 pm. facility LPN stated he should have clarified the orders when C1 had his suprapubic catheter placed . LPN stated he will be calling the urology clinic today to receive new orders to irrigate the catheter. A policy was requested but not provided.	W 331		
W 406	PHYSICAL ENVIRONMENT CFR(s): 483.470	W 406		

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W 406	Continued From page 8 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 when the facility failed to implement appropriate personal protective equipment (PPE) and CDC guidance for crisis staffing to prevent the spread of COVID 19. Findings include: See W455: The facility failed to implement the use of appropriate personal protective equipment (PPE) for staff and initiate client and staff testing during an outbreak. Additionally, they failed to follow CDC guidance for crisis staffing before allowing COVID positive staff to work with COVID negative clients and failed to implement isolation precautions or other strategies to reduce the spread of COVID in accordance to CDC guidance. These concerns had the potential to affect all 5 residents (C2, C3, C4, C5 and C6) in the home and resulted in an immediate jeopardy.	W 406	W406: Physical environment. The standard was not met as evidenced by observations of direct support staff demonstrating noncompliance with CDC guidance during a survey conducted by the department of health starting on August 25, 2022. All AXIS on White Bear Avenue staff and leadership will review and certify that they have reviewed current CDC guidelines for personal protective equipment. This education and retraining will be implemented by the house program supervisor and agency LPN. The implementation of this correction plan, which includes retraining of staff, will begin on September 1, 2022. The deficiency will be corrected when all AXIS on White Bear staff and leadership confirm review and understanding of current CDC guidelines. The plan of correction will be considered complete when all staff have verified review of guidelines, which will occur as soon as possible but not later than October 22, 2022.	
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 the use of appropriate personal protective equipment (PPE)	W 455		

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W 455	Continued From page 9 for staff and initiate client and staff testing during an outbreak. Additionally, they failed to follow CDC guidance for crisis staffing before allowing COVID positive staff to work with COVID negative clients and failed to implement isolation precautions or other strategies to reduce the spread of COVID in accordance to CDC guidance. These concerns had the potential to affect all 5 residents (C2, C3, C4, C5 and C6) in the home and resulted in an immediate jeopardy. The IJ began on 8/19/22, when the facility allowed two COVID positive staff to work with COVID negative clients from 8/19/22-8/30/22. Following those scheduled shifts, two clients tested positive for COVID on 8/25/22, (C2 and C3) and a third on 8/27/22 (C5). The administrator was informed of the IJ on 8/26/22, at 4:45 p.m. The immediate jeopardy was removed on 8/31/22, at 4:41 p.m. when the facility's approved removal plan was verified onsite by the state agency. Findings include: C2's Face Sheet undated indicated he had diagnosis of severe intellectual disabilities. C3's Face Sheet undated indicated he had diagnosis of severe intellectual disability and cerebral palsy. C4's Face Sheet undated indicated he had diagnosis of profound intellectual disability and cerebral palsy. C5's Face Sheet undated indicated he had diagnosis of profound intellectual disability and cerebral palsy. C6's Face Sheet undated indicated he had diagnosis of mild intellectual disabilities and sleep apnea.	W 455	W455: Infection control CFRs. The agency's staffing crisis plan was revised. The director of program services and the director of nursing will consider the implications and options of cohorting, evacuation and isolation before implementing the emergency staffing plans. Minutes from that meeting will be documented and provided to the surveyor upon reinspection. This was completed on 8/31/2022. Updated plan includes: when COVID is present in the home, gowns will be worn to provide personal care to residents. The program supervisor will monitor the implementation of this plan. This will be corrected on or before 8/31/2022. Additionally, clients will be tested immediately if they are experiencing symptoms of COVID. They will be tested on days 1, 3 and 5 following exposure, and immediately if they demonstrate any covid symptoms.	10/22/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	24G505	A. BUILDING _____ B. WING _____	C 09/01/2022

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W 455	Continued From page 10 During observation on 8/25/22, at 9:20 a.m. direct support professional (DSP)-A answered the door with a surgical mask and no eye protection on. During interview on 8/25/22, at 12:40 pm DSP-A stated he tested positive for COVID on 8/18/22, and he had symptoms of a cough but returned to work the next day. During interview on 8/25/22, at 10:00 a.m. DSP-A stated C3 was sent home from the day program today because she was not feeling well and had a runny nose and a cough. Additionally, C4 was also home from day program due to a COVID exposure on 8/24/22, at her day program. DSP-A additionally confirmed no clients at the home were on isolation precautions due to their exposure and/or COVID symptoms. During observations from 10:00 a.m. to 11:30 a.m. 8/25/22, staff were additionally not observed attempting to direct clients in the home (C2, C3, C4) to social distance, offer source control or disinfect areas of the home the clients were touching. C3 was observed handing musical toy back and forth with DSP-A with no observation of staff performing hand hygiene before touching computer keyboard or house telephone. In addition, during the lunch meal clients (C3, C4) were observed sitting directly next to each other for 20 minutes. In addition, C3 was observed to cough directly across the table while eating her lunch meal. Employee testing for COVID-19 and work schedule indicated the following: DSP-A tested positive for COVID-19 on 8/18/22,	W 455	Clients who are unwilling or unable to quarantine or social distance; a plan will be developed to minimize exposure to and from others. The program supervisor and QIDP will monitor. The deficiency will be corrected on 8/31/2022. Staff were trained on the proper cleaning techniques using a product to kill COVID 19 virus. The program supervisor will monitor this aspect of the plan of correction, to be completed on or before October 21, 2022.	

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W 455	Continued From page 11 and worked the following day 8/19/22, and continued to work his regular schedule at the home even though testing positive for COVID-19. DSP-A had symptoms of a mild cough. Review of facility schedule identified DSP-A worked 8/19/22, 8/21/22, 8/23/22, 8/24/22, 8/25/22, and 8/26/22. House Supervisor (HS) tested positive for COVID-19 on 8/25/22, and returned to work four days later on 8/29/22. Client testing for COVID-19 indicated the following: On 8/24/22, C4 was exposed to COVID-19 with a plan to stay home from work until 9/6/22. C4 was tested on 8/25/22 and was negative for COVID. On 8/25/22, C2 and C3 tested positive for COVID-19 at the home. On 8/27/22, C5 tested positive for COVID-19 at the home. Observation on 8/25/22 from 1:00 p.m. to 2:30 p.m., after all clients were tested and C2 and C3 tested positive for COVID, failed to reveal any implementation of C2 or C3 being placed on isolation, testing of staff implemented as a result of a facility outbreak, or additional precautions implemented to reduce the likelihood of the spread of COVID 19 such as increased disinfecting high touch areas, social distancing in common areas and encouraging clients to wear source control in common areas. During interview on 8/25/22, at 12:30 pm licensed practical nurse (LPN)-A confirmed DSP-A tested positive for COVID on 8/18/22, and due to	W 455	AXIS will continue to offer overtime pay and double pay to fill open shifts to meet minimum staffing levels. AXIS leadership will continue to work shifts in a staffing crisis situation per its COVID preparedness plan. AXIS will continue to monitor clients for COVID symptoms twice daily. The deficiency was corrected on 8/31/2022. AXIS leadership will continue to work shifts in a staffing crisis situation per COVID preparedness plan. The deficiency was corrected on 8/31/2022. Implementation of the plan of correction is ongoing and will be monitored by the program supervisor and QIDP weekly.	

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W 455	Continued From page 12 "staffing crisis" returned to work on 8/19/22. During observation on 8/26/22, at 1:30 p.m. director of nursing (DON) was observed to be in C2's (positive for COVID) room along with DSP-A to complete a nursing assessment on a newly placed suprapubic catheter, neither had a gown on and the DON failed to have appropriate eye protection on. During interview on 8/26/22, DSP-A stated he had not been wearing a gown with COVID positive clients at this home like he had in others and was not sure where the gowns were located. During interview on 8/26/22, at 2:00 p.m. with DON stated staff should be wearing a gown when in the room providing personal cares and she should have had her eye protection on. During interview on 8/26/22, at 2:15 p.m. program director (PD) stated the agency had allowed DSP-A and HS to work after testing positive before the required 10 day quarantine window since they were in a "staffing crisis". The PD stated they have a 1 staff to 4 client ratio and both were needed to work. During observation and interview on 8/30/22, at 11:00 a.m. HS was at the home wearing a N95 mask, gown and eye protection. The HS stated since they are in a "staffing crisis" she was allowed to work and in fact worked yesterday 8/29/22, for a few hours as well. The HS stated their minimum staffing levels would be 1 staff to 4 clients but confirmed there was an additional staff also working today and yesterday which actually made for a two to three staffing ratio given only three clients were home. When asked if she	W 455		

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W 455	Continued From page 13 knew why she was working if the ratio was more than 1 to 4 with her there, HS said she did not know. Review of the schedules from 8/19/22 through 8/29/22, reflected that management (leadership supporting the HS) were not on the schedule assisting with shifts and that the program was utilizing more than a 1 to 4 ratio most days and during days the COVID positive staff were working, which made for an unnecessary exposure to have those staff at work. Review of the schedule for August lacked evidence the program was in a staffing crisis based on CDC guidance. Review of Provisions during Staffing Crises for Allowing Covid Positive Employees who have Tested Positive to Work updated 3/23/22 indicated: -In certain circumstances during an extreme staffing crisis staff who have tested positive but who are asymptomatic or have minor symptoms may be allowed to work while adhering to strict, highest level PPE use if there are no other options for maintaining adequate staffing in the home. This can only be authorized by the COVID-19 Preparedness Plan Administrator or the Director of Nursing. Interview with administrator on 8/26/22, at 2:30 p.m. regarding the facility's staffing procedures and determining the use of COVID positive staffing the administrator stated the facility was in a "staffing crisis" and had determine they needed to bring back staff who had tested positive for COVID but were not symptomatic to assist with open shifts. When asked what steps the facility	W 455		

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W 455	Continued From page 14 had taken to ideally prevent the use of COVID positive staff, the administrator stated management was assisting with shifts but not all shifts could get filled. When asked if the facility had attempted to work with staffing agency for coverage, cancel unnecessary appointments or outings, offer incentives, etc. the administrator stated no and the agency could not afford to pay for agency staff help through the state. Additionally, when asked what the minimum staffing level at the homes were, the administrator stated for health and safety in the homes we maintain a 1:4 ratio of staff to clients and this is how we would determine our staffing crisis levels. Emergency Staffing Plan During a Pandemic Event or Staffing Crisis updated 8/29/22, indicated the facility will activate its contingency staffing plan if -it has exhausted all options to address staffing needs, triggering a crisis level of staffing -it has exhausted all options to cohort COVID-19 positive residents internally or transfer positive residents to COVID-19 care sites -if the only remaining approach to ensure adequate resident care and safety is the evacuate the facility. In certain circumstances if all attempts described above have not provided adequate coverage, staff who have tested positive for COVID-19 but who are asymptomatic or have minor symptoms may be allowed to work while adhering to strict, highest level PPE use if there are no other options for maintaining adequate staffing. Axis Screening and policies for clients exhibiting signs or symptoms of COVID-19 dated 3/23/22 indicate; Prompt Identification and Isolation of Sick	W 455		

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W 455	Continued From page 15 Persons: -Clients of Axis programs have their temperature and O2 saturations taken and recorded daily. Staff also document if any client shows symptoms of respiratory illness that may be related to COVID-19. If symptoms are observed, staff contact the Axis nurse who would send the person to the clinic or hospital for evaluation and testing. -Infected clients will be quarantined and remain in their private bedrooms. Staff will serve their meals in their bedrooms and provide bed baths in their rooms rather than showers. If they need to leave the room, staff should assist them to wear a face mask. -When assisting a person with a confirmed case of Coronavirus, staff use extra precautions and wear personal protection equipment (PPE) as described above. When finished, they remove their PPE mask, gown and gloves and dispose of these in the trash can of the same room, wash hands with soap and water and use sanitizer. The immediate jeopardy that began on 8/19/22, was removed on 8/31/22, when an onsite visit verified through interview, observation and record review confirmed policy revisions, training for all staff on appropriate PPE use and isolation/quarantine practices, testing implementation, policy updates and removal of COVID positive staff working with COVID negative clients.	W 455		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 15, 2022

Administrator
Axis On White Bear Avenue
3516 White Bear Avenue
White Bear Lake, MN 55110

Re: Enclosed State Supervised Living Facility Licensing Orders - Project Number Event ID: CBNY11

Dear Administrator:

The above facility was surveyed on August 25, 2022 through September 1, 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 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:

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

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 Susie Haben. 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.

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.

Minnesota Department of Health

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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 8/25/22 through 9/1/22. a complaint investigation was conducted. Your facility was found to be not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaints were found to be SUBSTANTIATED: HG5054274C (MN86084) with licensing orders issued at 0380. When corrections are completed, please sign and	5 000	Susie Haben	

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5 000	Continued From page 1 date, make a copy of these orders and electronically return to: Susie.haben@state.mn.us	5 000		
5 380	MN Rule 4665.3300 PURPOSE OF HEALTH SERVICES. Health services shall be utilized to maintain an optimal general level of health and to maximize function, prevent disability, and promote optimal development of each resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nursing services were implemented related to following physician orders and plan of care for 1 of 1 client (C1) who had a seizure disorder and was hospitalized and expired. In addition, the facility failed to clarify physician orders for 1 of 1 clients (C2) who had a suprapubic catheter which was not irrigated and received a urinary tract infection (UTI) and was hospitalized. Findings include: C1's Face Sheet undated, indicated C1 had severe intellectual disabilities, seizure disorder, vagus nerve stimulator VNS (used to treat epilepsy) and cerebral palsy. C1's Care Plan dated 2/21/22, indicated he can not cry out loud if needed, required staff to use a lift to transfer, can reposition in bed, used wheelchair with history of seizures. The care plan further indicated staff were to check C1	5 380		

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5 380	Continued From page 2 every two hours and assist him with freshening up as needed. In addition the care plan indicated he had diagnosis of Epilepsy and seizure disorder. An Internal Reporting and Investigation dated 8/18/22, at 5:00 a.m. indicated direct support professional (DSP)-B completed his nightly checks with C1 at 12:00 a.m. and 2:00 a.m. and C1 was found sleeping with no concerns. DSP-B went to get C1 up for the day at 5:00 a.m. and C1 was noticed to be cold to the touch and had foam around his mouth. DSP-B checked for pulse called 911 and performed CPR. During interview on 8/25/22, at 4:00 p.m. DSP-B stated he worked the night shift with C1 on 8/18/22, and completed his usual checks at 12:00 a.m., 2:00 a.m. and went to get him up at 5:00 a.m. and found him not breathing, had foam around his mouth and called 911 and started CPR. The paramedics arrived and the medical examiner removed his body since he passed away. A Coroner's report was requested but not received. Seizures Review of C1's Seizures and hospitalizations indicated the following: On 2/3/22, had seizure and went to emergency department (ED) and diagnosed with urinary tract infection (UTI). On 3/6/22, had 2 minute seizure, went to ED. On 4/27/22, had a 2 minute seizure at 11:50 a.m., used VNS magnet and came out of seizure 30 seconds (NO ER Visit DOCUMENTED).	5 380		

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5 380	Continued From page 3 On 5/13/22, had a 2 minute seizure around 12:30 p.m., used VNS magnet, effective. On 5/16/22, had 1 min seizure and 30 seconds, VNS magnet worked, stopped seizure with in 20 seconds. On 6/18/22, had seizure, went to ED. Went to follow up neurologist on 6/29/22, seizure medication increased. On 7/12/22, had seizure, went to ED. After Visit Summary dated 7/12/22, indicated to schedule an appointment with neurology as soon as possible for a visit. Record review and interview with the clinic indicated the appointment was not scheduled until 8/11/22, by the HS for 9/9/22. (Almost 2 months later). On 7/24/22, had seizure went to ED. After Visit Summary on 7/24/22, indicated C1 was to be seen by primary physician as soon as possible. Record review lacked evidence this appointment was scheduled. On 8/1/22, seizure at day program noted, review of facility records lacked details and documentation of this seizure (type of seizure, time, length, if VNS magnet was administered). On 8/2/22, seizure at day program noted, review of facility records lacked details and documentation of this seizure (type of seizure, time, length, if VNS magnet was administered). On 8/5/22, seizure at day program went to ED, review of facility records lacked details and documentation of this seizure. On 8/8/22, seizure at day program went to ED, review of facility records lacked details and documentation of this seizure. On 8/15/22, seizure at day program noted, review of facility records lacked details and documentation of this seizure (type of seizure, time, length, if VNS magnet was administered). On 8/17/22, seizure at day program noted, review of facility records lacked details and	5 380		

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5 380	Continued From page 4 documentation of this seizure (type of seizure, time, length, if VNS magnet was administered). During interview on 8/25/22, at 10:08 a.m. facility licensed practical nurse (LPN)-A stated the day program should be informing us when C1 had seizures while there. LPN stated he was unable to locate documentation of C1 having seizures at the day program but knows he has had several seizures there. LPN-A added, we were aware of some of the seizures because C1 was sent to the ED during some a few of the seizures but not all, whether the day program contacted us or not is hard to tell because our records do not indicated either way. During interview on 8/25/22, at 11:00 a.m. HS stated she was unable to find documentation of C1's seizures at the day program and there should be documentation in the chart. In addition, the HS stated she did make C1's appointment to be seen by the neurologist and does not recall why it was made late and missed making a follow up appointment for C1 to be seen for a follow up visit with primary physician. During interview on 8/25/22, at 4:26 p.m. receptionist from Minnesota Epilepsy Group stated they received a call from the HS on 8/11/22, appointment was made for C1 to be seen on 9/9/22. The receptionist stated when client's receive orders from the hospital or ED visits to be seen, they do save special spots for clients to be soon sooner if requested. The receptionist stated she did not see any request for C1 to be seen sooner. During interview 8/29/22, at 11:39 a.m. registered nurse (RN)-B from C1's neurology clinic stated C1 had a severe form of epilepsy and did expect	5 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22847	A. BUILDING: _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIS ON WHITE BEAR AVENUE	3516 WHITE BEAR AVENUE WHITE BEAR LAKE, MN 55110

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5 380	Continued From page 5 to be informed of all ED visits related to a seizure. RN-B stated in review of records with surveyor, it appeared they were not informed of the ED visit on 8/5/22 and should have been. Additionally, RN-B stated even though C1 did miss an appointment the ED wanted scheduled back in July of 2022, the doctor did not feel this would have prevented him from his passing as he was evaluated in the ED several times before and had medication changes leading up to what was believed to be his final seizure (though no official cause of death had been released). C2's Face Sheet undated indicated he had diagnosis of severe intellectual disabilities, history of urinary tract infections and had suprapubic catheter. C2's Physician orders dated 6/16/22, indicated C1 had 18 french (FR) Foley catheter, irrigate catheter weekly, instill 60 milliliters (ML) of saline, gently withdraw the saline, look for mucus debris, discard saline, repeat until clear. A Referral Form dated 5/5/22, from urology indicated C1 will have a suprapubic catheter insertion. Attached with the referral indicated patient education instructions which included Suprapubic Catheter Care. The instructions indicated to complete weekly, irrigation of the catheter. A Referral Form dated 8/8/22, indicated C1 had a suprapubic tube inserted. The referral indicated under follow up: Change tube 6 weeks at Gillette Clinic-Life time. During observation and interview on 8/25/22, at 12:00 p.m. C1 was observed to be sitting by the kitchen table with a leg bag attached to his	5 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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5 380	Continued From page 6 suprapubic catheter. C1's urine was dark yellow in color. LPN stated C1 recently had a suprapubic catheter placed due to increased UTI's and they are trying to have him increase his fluid intake. During interview on 9/1/22, LPN stated when C1 returned from having his suprapubic catheter placed he discontinued his previous weekly catheter irrigations since he thought you would not irrigate a suprapubic catheter. During interview on 8/30/22, at 11:45 a.m. HS stated C1 was admitted to the hospital on 8/29/22, with diagnosis of UTI and bowel obstruction. During interview on 9/1/22, at 2:30 p.m. urologists nurse registered nurse (RN)-C stated after a newly placed suprapubic catheter placement you should not irrigate for the first 14 days and then irrigations should resume. RN-C stated C1 should have had his catheter irrigated on 8/22/22. The RN did stated C1 might have already had the UTI and was uncertain if that was the cause of his hospitalization. During interview 9/1/22, at 2:45 pm. facility LPN stated he should have clarified the orders when C1 had his suprapubic catheter placed . LPN stated he will be calling the urology clinic today to receive new orders to irrigate the catheter. A policy was requested but not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 380		