Delivered Via Email
March 16, 2022

Administrator
Hoffmann Center
1715 Sheppard Drive
Saint Peter, MN 56082

Re: Event ID: TINN12

Administrator:

A revisit survey was conducted on March 14, 2022 to follow up on deficiencies issued related to a certification survey exited on January 31, 2022. Your facility was found to be in compliance with the Conditions of Participation (COP) at 483. subpart G for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21.

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

Sincerely,

Amy Johnson
Minnesota Department of Health

February 10, 2022

Electronically Delivered Via Email:

Administrator
Hoffmann Center
1715 Sheppard Drive
Saint Peter, MN 56082

Event ID: TINN11

Dear Administrator :

On January 31, 2022, a survey was conducted at Hoffmann Center by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the Conditions of Participation (COP) at 483. subpart G for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21. The facility was found not in compliance.

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:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action

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

- Include signature of provider and date.

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

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

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

Please feel free to call me with any questions.
Sincerely,

Amy Johnson

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24L003	A. BUILDING _____ B. WING _____	C 01/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOFFMANN CENTER	**1715 SHEPPARD DRIVE SAINT PETER, MN 56082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments On 1/28/22, and 1/31/22, a complaint investigation was conducted at Hoffmann Center by the Minnesota Department of Health (MDH) to determine compliance with the Conditions of Participation (COP) at §483. subpart G for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21. The facility is NOT in compliance. A condition level deficiency was issued at N-0100, with a standard level issued at N-0120 The following complaint was found to be substantiated: HL003003C (MN79547), however, NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be unsubstantiated: HL003002C (MN80383) and HL003004C (MN80524).	N 000		
N 100	USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: The Psychiatric Residential Treatment Facility (PRTF) was found to be out of compliance with the Condition of Participation (COP) when the facility failed to ensure staff were vaccinated with at least one dose of the Coronavirus Disease	N 100		

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

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N 100	Continued From page 1 2019 vaccine, or have a medical or non-medical exeption. In addition, the facility failed to develop a policy requiring staff who were not fully vaccinated or staff who had exemptions to have additional infection control prevention interventions. Due to the serious nature of this failure, the facility is unable to ensure adequate protection of residents. Therefore, the facility is unable to meet COP at 483. subpart G for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities. Findings include (see N-0120): Based on observation, interview, and document review, the facility failed to follow the Center for Clinical Standards and Quality/Quality, Safety & Oversight Group (QSO) QSO-22-09-ALL memorandum and ensure all staff were vaccinated with at least one dose of the Coronavirus Disease 2019 (COVID-19) vaccine, failed to develop a policy to implement additional infection control practices for staff who have not completed their primary vaccination series or who had exemptions, and failed to implement additional infection control precautions for staff who have not completed their primary vaccination series or who had exemptions to the COVID-19 vaccine.	N 100		
N 120	COVID-19 Vaccination of Facility Staff CFR(s): 441.151(c)(1)-(3)(i)-(x) § 441.151 General requirements. (c) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully	N 120		

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N 120	Continued From page 2 vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (c)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the center setting and who do not have any direct contact with residents and other staff specified in paragraph (c)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (c)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for	N 120		

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N 120	Continued From page 3 whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring that the facility follows nationally recognized infection prevention and control guidelines intended to mitigate the transmission and spread of COVID-19, and which must include the implementation of additional precautions for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (c)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not	N 120		

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N 120	Continued From page 4 the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (c)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by:	N 120		

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N 120	Continued From page 5 Based on observation, interview, and document review, the facility failed to follow the Center for Clinical Standards and Quality/Quality, Safety & Oversight Group (QSO) QSO-22-09-ALL memorandum and ensure all staff were vaccinated with at least one dose of the Coronavirus Disease 2019 (COVID-19) vaccine, failed to develop a policy to implement additional infection control practices for staff who have not completed their primary vaccination series or who had exemptions, and failed to implement additional infection control precautions for staff who have not completed their primary vaccination series or who had exemptions to the COVID-19 vaccine. Findings include: On 1/28/22, at 2:30 p.m. the executive director (ED) was interviewed and stated there were staff who have not received their first COVID-19 vaccination. The ED further stated the facility has worked hard trying to get staff vaccinated or to submit their exemptions, but it had not been successful. On 2/1/22, at 9:45 a.m. the director of nursing (DON) stated there were staff who had not been vaccinated and/or had not submitted their exemption request. The facility COVID-19 Vaccination Log was reviewed with the DON, and identified eleven staff who had not received a first dose of the COVID-19 vaccine, nor had submitted a request for an exemption. The DON stated staff were required to be vaccinated by 1/27/22. The DON stated there were a few staff who would refuse the vaccine and did not qualify for an exemption, and she was unsure what the next steps would be for them. The DON stated	N 120		

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N 120	Continued From page 6 the facility conducted weekly testing of non-vaccinated and exempt staff, and currently there were no staff who were COVID-19 positive. Current number of staff who had at least 1 vaccination, or who had provided exemptions was 88.5% On 2/01/22, at 1:59 p.m. youth counselor (YC)-A was interviewed and stated he was not vaccinated, but had just delivered a non-medical exemption form to the administration building. YC-A was observed wearing a surgical face mask. On 2/01/22, at 4:45 p.m. accreditation coordinator indicated she did not see the requirement that non-vaccinated or exempt staff were required to have additional infection control practices implemented. The facility COVID-19 Vaccination Policy dated 12/28/21, directed by 1/27/22, all staff must have received at least one dose of the COVID-19 vaccination, have a pending request for, have been granted a qualifying exemption, or be identified as having a temporary delay as recommended by CDC. The policy lacked direction on additional infection control practices for staff who are not fully vaccinated or who have exemptions.	N 120		

Date: February 28, 2022 (Revision)

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, MN 55802-2007

N 120

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

   As of February 25th, 2022 all residential staff have received a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine, or have an approved exemption except the following:

   One administrative staff who has only received one dose of a multi-dose vaccine. This staff has limited contact with residents and is scheduled to receive the 2nd dose on 3/12/22.

   Employee COVID-19 Vaccination Policy has been updated to meet all requirements of QSO-22-07-ALL and QSO-22-09-ALL. Policy is included for review.

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

   All residents, specifically residents who have not been vaccinated, experienced increased risk of contracting COVID-19 including risk of serious illness and/or death due to the deficient practice.

3. Address what measures will be put into place or systemic changes made to ensure the deficient practice will not recur.

Prior to setting up an interview, candidates will be asked regarding their vaccination status. If vaccinated, potential employees will be required to provide verification of COVID-19 vaccination during the interview process. This will be verified through the Minnesota Immunization Information Coalition. If unvaccinated, exemption forms will be provided to the potential employee during the interview process. Any potential job offers are contingent on the employee providing verification of being fully-vaccinated (completed primary vaccination series plus 14 days) or providing qualifying exemption prior to 1st day of employment.

Contingency Plan for Unvaccinated and Exempted Employees

The prevalence of COVID-19, in particular the Delta variant, within health care settings increases the risk of unvaccinated staff contracting the virus and transmitting the virus to clients. When staff cannot work because of illness or exposure to COVID-19, the strain on LAHC and

the entire health care system becomes more severe and further limits patient access to safe and essential care.

Weekly testing: Exempted employees and employees who have not completed their primary vaccination series will be subject to weekly COVID-19 testing to ensure they do not have the virus. Weekly testing will begin the week of 1/31/2022-2/5/2022. Options for testing include:

- Weekly testing in the residential nursing office will be conducted at no charge to employees. Employees should report to the nursing office before their first scheduled shift of the week. Tests used will be rapid tests that provide results within 15-30 minutes;

- Employees may also use outside sources (clinics, pharmacies, at home tests, etc.) for their weekly COVID-19 testing at their own cost. Results must be submitted to the nursing department on Thursdays verifying results and date of testing. Employees choosing off-campus testing methods via clinics or pharmacies should test weekly on Mondays to ensure results can be routed to nursing on Thursday of each week. If the employee has not received their results by Thursday, they should report to the nursing office for on-campus testing.

- Weekly COVID-19 testing for all employees with medical and/or religious exemptions will continue until the pandemic has cleared. Weekly COVID-19 testing for employees who are not fully vaccinated will continue until the employee is fully vaccinated. Affected individuals will be notified via email at such time that testing is no longer needed.

- Any alternative arrangements for testing (due to vacation, illness, etc.) must be made in writing (via email) to both the Director of Nursing and the employee's supervisor prior to the scheduled testing day. Failure to comply with weekly COVID-19 testing requirements will result in an employee being removed from the schedule immediately. Employees will be reinstated once they are back in compliance with weekly testing requirements.

- LAHC Nursing will continue to offer free on-demand COVID-19 testing for all employees with possible exposure or symptoms regardless of vaccination status as long as tests are available.

Source Control: All employees will wear a well-fitting surgical facemask and protective eyewear while on duty. Exempted employees and employees who are not fully vaccinated will be required to wear NIOSH-approved N95 or equivalent or higher-level respirator for source control if they are working on a unit with a COVID-19 positive client. When possible, exempted employees and employees who are not fully vaccinated will be reassigned to a unit free of COVID-19 positive clients.

As an additional precaution, employees who are not fully vaccinated are asked not to eat in the dining hall when clients and other staff are present. They are asked to eat at a time and in a location where they can be by themselves.

Daily Temperature and Symptom Screening:

All employees will complete the daily temperature and symptom screen when reporting to work and document this data (absence of fever, absence of symptoms, and absence of recent COVID-19 exposure) on the "Employee COVID-19 Screening Log." Employees who have tested positive, are displaying symptoms consistent with COVID-19, or who had close contact or a higher-risk exposure with someone with COVID-19 need to contact nursing staff (see Management of Symptomatic Staff Policy for further information). This is especially important for employees who are not fully vaccinated. If employee experienced a high-risk exposure they will need to get tested and follow current guidance from the Minnesota Department of Health.

Social Distancing:

All staff are encouraged to practice physical distancing measures in all areas and during all interactions, including during staff-only meetings, staff offices, kitchen, etc. Employees who are not fully vaccinated should assign a fully vaccinated co-worker to client care duties where physical distancing cannot be maintained as to not interfere with the provision of care while maintaining an optimum level of safety for residents.

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

Nursing staff will continue to monitor the Minnesota Immunization Information Coalition to ensure accuracy of staff reporting in regards to vaccination status. Excel spreadsheets have been created to track all employees regarding vaccination status, approved exemptions, and required weekly testing. Tracking will be reviewed on quarterly basis, or more often as needed. Nursing staff will notify supervisors of employees who are out-of-compliance with the weekly testing requirement so they can be removed from the staff schedule until they are back in compliance with the requirement.

5. Include dates when corrective action will be completed. 3/12/2022