DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
CMS Certification Number (CCN): 245366

May 9, 2022

Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, MN 55811

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 4, 2022 the above facility is certified for:

140 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 140 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K271 K321 and K364.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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Electronically delivered
May 9, 2022

Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: March 3, 2022

Dear Administrator:

On March 15, 2022, we notified you a remedy was imposed. On April 13, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 4, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 14, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 15, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 14, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 4, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Your request for a continuing waiver involving the deficiencies cited under K271 K321 and K364 at the time of the March 3, 2022 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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Electronically delivered

May 9, 2022

Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, MN 55811

Re: Reinspection Results
Event ID: 1UWU12

Dear Administrator:

On April 13, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 13, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
March 15, 2022

Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: March 3, 2022

Dear Administrator:

On March 3, 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 skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 14, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 14, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 14, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 14, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Chris Jensen Health & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 14, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 3, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@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
	245366	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	**2501 RICE LAKE ROAD DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On February 28, 2022 through March 3, 2022, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		4/1/22

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

Electronically Signed | 03/22/2022

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 039	Continued From page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or	E 039		

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E 039	Continued From page 2 (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from	E 039		

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E 039	Continued From page 3 engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the	E 039		

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E 039	Continued From page 4 onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039		

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E 039	Continued From page 5 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 6 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 7 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is	E 039		

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E 039	Continued From page 8 led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039		

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E 039	Continued From page 9 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure exercises to test the Emergency Preparedness Plan were conducted at least annually, including participation in a full-scale table-top exercise. This had the potential to affect all 112 residents. Findings include: On 3/3/22, the facilities Emergency Preparedness Plan (EPP), undated, was reviewed. The EPP failed to address an annual full-scale, internal, or table-top exercise to test the facility's response to an emergency over the past three years. Facility provided document, Mandatory Emergency Preparedness Training, undated, noted the last scheduled full-scale training was scheduled on 5/9/18 and 5/30/18. On 3/3/22, at 12:45 p.m. the Administrator confirmed she was not aware of another training completed for the years 2019, 2020 and 2021 and was not able to find documentation that trainings were scheduled for those years. Facility provided document, Training and Testing, undated, instructed training on emergency	E 039	E039: EP Testing Requirements Corrective Action: ED/DON/Maintenance Director/EVS Director immediately re-educated on the criteria for Testing Requirements – Emergency Preparedness Deficient practices were corrected to meet the Emergency Plan by completing a Table-Top Exercise. A list of scheduled Table-Top Exercises has been created and scheduled. Log was generated to monitor and ensure the Emergency Plan is being exercised to meet requirements. Identification of other Residents: All residents could be impacted by Testing Requirements Monitoring Mechanism: ED/Designee will audit the completion of Table-Top Exercises - Quarterly X 1 year Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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E 039	Continued From page 10 preparedness will be conducted in the following forms: 1. Orientation 2. Annually- all staff will be trained and refreshed on our emergency preparedness planning and procedures on an annual basis. 3. Testing drill- annually the plan and policy will be drilled and tested site wide.	E 039	Date of compliance: 4/1/2022	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.	E 041		3/21/22

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E 041	Continued From page 11 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park,	E 041		

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E 041	Continued From page 12 Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code, section, 9.1.3, and the 2010 edition of National Fire Protection Association (NFPA) Standard 110, Standard for Emergency and Standby Power Systems, section 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	E 041	Corrective Action: ED/DON/Maintenance Director/EVS Director immediately re-educated on the criteria for Hospital CAH and LTC Emergency Power Deficient practices were corrected to meet the Life Safety Statute by education and audit system in place. Identification of other Residents: All residents could be impacted by Hospital CAH and LTC Emergency Power Monitoring Mechanism:	

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E 041	Continued From page 13 1. On 03/01/2022, at 11:40 AM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Maintenance Supervisor, that the facility could not provide 2 of 12 monthly emergency generator test and inspection documentation. 2. On 03/01/2022, at 11:40 AM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Maintenance Supervisor, that the facility could not provide 8 of 52 weekly emergency generator inspection documentation. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	E 041	ED/Designee will audit Generator inspection logs - Weekly times 1 year Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 3/21/2022	
F 000	INITIAL COMMENTS On February 28, 2022 through March 3, 2022, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5366272C (MN80194), H5366274C (MN79484), H5366277C (MN81221), H5366278C (MN81294), H5366279C (MN81223), H5366280C (MN81417), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5366271C (MN80406),	F 000		

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F 000	Continued From page 14 H5366273C (MN79851), H5366275C (MN79435), H5366276C (MN79207). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		4/1/22

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F 584	Continued From page 15 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to clean and maintain wheelchairs for 3 of 3 residents (R10, R34, R50) reviewed for dirty wheelchairs. Findings include: start with R10 R10 was observed on 3/2/22, at 8:39 a.m. eating on her own with her fingers, dropping food onto her lap and wheelchair. On 3/2/22, at 1:37 p.m. nursing assistant (NA)-D stated the wheelchairs on the unit were "pretty dirty". NA-D stated R10's and R34's were wheelchairs that needed to be cleaned. NA-D stated someone on the night shift used to clean the wheelchairs on the unit. NA-D was unsure	F 584	Immediate Corrective Action: R10, R34, and R50□s wheelchairs were cleaned to provide a Safe/Clean/Comfortable Homelike Environment IDT immediately re-educated on the criteria for Safe/Clean/Comfortable Homelike Environment Corrective Action as it applies to others: Resident wheelchairs will be audited, and cleaned as needed, to provide a Safe/Clean/Comfortable Homelike Environment. All resident wheelchairs were audited and cleaned if identified and schedule for routine cleaning/auditing was put in place.	

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F 584	Continued From page 16 about how wheelchairs were currently getting cleaned. On 3/2/22, at 3:00 p.m. R10 was seated in her wheelchair in the day room with family. Dried, raised white/yellow substances were noted on the side of her wheelchair, with white/yellow crusted matter down the metal side of the wheelchair in an area about three inches by four inches. There was dried white matter on both armrests of the wheel chair. On 3/2/22, at 3:05 p.m. NA-E verified the presence of the dried substances on R10's wheelchair stating, "that's not right, we need to get that cleaned up." On 3/2/22, at 7:04 a.m. nursing assistant (NA)-C assisted R34 with cares. R34's Broda chair was along the wall and had several dried white spots on the left side of the seat, the inside of both arm rests, and on the top of the left arm rest. There were several brown spots on the foot rest. NA-C verified the Broda chair looked dirty and said someone on nights used to go around and clean the chairs. NA-C volunteered that almost everyone's chair should be cleaned. R50's wheelchair was observed on 2/28/22, at 2:56 p.m. to have several white splatters on the wheels, and arm rests approximately 2 inches round. Several long, white streaks were observed on the side panels, both inside and outside of the wheelchair. A large dried, unidentified substance, was noted on the right brake and brake handle. On 3/3/22, at 8:10 a.m. R50's wheelchair was observed, unchanged from the above observation.	F 584	Prevent recurrence: The policy and procedure for Wheelchair cleaning was reviewed and revised. All staff will be re-educated on the policy. Ongoing Monitoring: DON/Designee will audit 5 residents wheelchairs for cleanliness. - Daily X 1 week - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 90 days for further recommendations. Date of compliance: 4/1/2022	

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F 584	Continued From page 17 On 3/3/22, at 8:27 a.m. nursing assistant (NA)-H confirmed the appearance of R50's wheelchair. NA-H stated she was not aware if there was a schedule for wheelchair cleaning. Staff were to notify housekeeping when a wheelchair needed to be cleaned. On 3/3/22, at 8:59 a.m. registered nurse (RN)-C stated there was no one assigned to clean wheelchairs. However, if staff see it dirty, they are supposed to clean it. RN-C stated she did not know the last time R50's wheelchair had been cleaned. On 3/3/22, at 9:28 a.m. registered nurse (RN)-C stated the wheelchairs used to be cleaned on the night shift, however, the staff had not been able to clean wheelchairs. RN-C verified there was not a current procedure in place to clean wheelchairs. RN-C verified she expected staff to clean a wheelchair if it was brought to their attention. RN-C was not sure when the last time R10's wheelchair had been cleaned. On 3/3/22, at 9: 47 a.m. the maintenance director verified there was a wheelchair washer in the facility and the director of environmental services (EVS) was going to re-initiate a wheelchair washing procedure, however, there was not an active procedure in place. On 3/3/22, at 9:51 a.m. EVS stated the wheelchair washer needed to be repaired and had no records of wheelchairs being washed. On 3/3/22, at 10:31 a.m. the nurse consultant (NC) verified wheelchairs should be cleaned regularly and he expected staff to clean a	F 584		

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F 584	Continued From page 18 wheelchair when it appeared dirty. The facility policy titled Wheelchair Washing, Preventative Maintenance and Repair dated 3/3/06, directed nursing staff to wipe down wheelchairs as needed and to remove any food particles or spilled liquids. In addition the policy directed environmental staff to run the wheelchairs through the wheelchair washer on a scheduled, rotational basis, with one wings wheelchairs to be washed weekly. The policy directed environmental services to keep a log sheet of wheelchairs that were cleaned.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		4/1/22

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F 657	Continued From page 19 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include smoking resident for 2 of 4 residents (R362) who were identified as smokers. Findings include: R362's Admission Record, printed 3/2/22, indicated the diagnoses of chronic respiratory failure and emphysema. R362's minimum data set (MDS) dated 2/16/22, identified R362 was cognitively intake and required extensive assistance with activities of daily living. R362's medical record and smoking assessment, dated 2/20/22, indicated R362 had the ability to smoke independently. During observation on 3/01/22, at 9:14 a.m. R362 was smoking in the facility's designated smoking area. R362 was able to light, ash and dispose of the cigarette appropriately. R362's care plan, dated 2/28/22, lacked documentation that R362 was a smoker. During interview on 3/02/22, at 1:26 p.m. unit manager (RN)-A verified R362 was a current smoker and facility documentation lacked evidence that resident was a current smoker. A review of the facility policy, entitled: Care Plan -	F 657	Immediate Corrective Action: R362□s care plan was assessed and updated for accuracy IDT immediately re-educated on the criteria for care planning and revision Corrective Action as it applies to others: Resident care plans will be audited and revised as needed. All residents who identified as smokers care plans were reviewed to ensure smoking safety interventions are being implemented. Prevent recurrence: The policy and procedure for Care Plan □ Reviews and Conferences reviewed and remains current. Licensed Nurses re-educated on the Policy. Monitoring Mechanism: DON/Designee will audit the accuracy and time of 5 resident care plans - Daily X 1 week - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks Audit results will be reviewed at QAPI to determine the need to continued	

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F 657	Continued From page 20 Reviews and Conferences (revision dated of May 2020) indicated: "The community will conduct a care plan review/conference at least quarterly, and as needed, that is interdisciplinary, provides an in-depth review of the resident's plan of care, and provides an opportunity for resident and resident representative and/or family discussion/input."	F 657	monitoring and compliance. Date of compliance: 4/1/2022	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure nail care was provided to 1 of 4 residents (R35) whom were dependent upon staff for activities of daily living (ADL's). Findings include: R35's quarterly Minimum Data Set (MDS) dated 1/6/22, indicated R35 required assistance from another person for ADLs including personal hygiene. R35 was not able to communicate his needs. R35's face sheet, printed 3/2/22, noted diagnoses included neurological injury. R35's care plan, undated, indicated R35 required assist from one staff for hygiene. On 3/2/22, at 11:08 a.m. R35 was observed to	F 677	Immediate Corrective Action: R35□s nails were trimmed, bath day audited for accuracy IDT immediately re-educated on the Nail Care Policy Corrective action as it applies to others: Residents will be audited, and nails will be trimmed as needed. All resident who were identified during audit nails were trimmed as allowed by resident. Prevent recurrence: The policy and procedure Nail Care reviewed and remains current. Nursing staff were re-educated on the Nail Care Policy Ongoing Monitoring:	4/4/22

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F 677	Continued From page 21 have 1/4-inch-long fingernails on both hands. Both hands had fingers wrapped around a washcloth. The fingernails on the third and fourth fingers of each hand were pressing on the palms of his hands. No redness was noted where the nails were pressing. On 3/2/22, at 1:33 p.m. nursing assistant (NA)-B stated fingernails were supposed to be trimmed on R35's bath day (Wednesday) and as needed. NA-B confirmed R35's fingernails were long and likely not trimmed on his last bath day (2/23/22). NA-B stated R35 does not resist nail care. On 3/2/22, at 1:45 p.m. registered nurse (RN)-A confirmed R35's nails were long and the nails on the third and fourth fingers of each hand, were pressing on the palms of his hands, and the length of R35's nails was more than a week's worth of growth. RN-A stated she expected nail care, including trimming, was done on the resident's bath day, and as needed. RN-A stated R35 was at risk for scratching himself with long nails and pressure injury because of the nails pressing into the palms of his hands. Facility policy, Nail Care, dated 4/1/08, indicated the procedure for nail care included fingernails are trimmed weekly during bathing or more often, if necessary.	F 677	DON/Designee will audit nail care of 5 residents - Daily X 1 week - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 4/4/2022	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		4/4/22

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F 684	Continued From page 22 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a skin tear was adequately monitored to ensure healing for 1 of 1 residents (R92) reviewed for non-pressure skin issues. Findings include: R92's quarterly Minimum Data Set (MDS), dated 2/10/21, indicated cognition was moderately impaired with clear speech, was able to make self-understood to others, and required staff assistance with all activities of daily living (ADL). A progress note dated 2/20/22, indicated a skin tear was identified on R92's left hand with the skin tear cleaned, skin closure strips applied and covered with a Mepilex dressing. R92's Weekly Skin Check dated 2/21/22, did not indicate the skin tear. R92's Weekly Skin Check dated 3/1/22, did not indicate the skin tear. R92's medical record lacked additional assessments, monitoring, or treatments to the skin tear. During observations on 2/28/22, at 12:39 p.m. a Mepilex foam dressing with "2-20 BB" written on it, was observed on the top of R92's left hand. R92 stated that he had a skin tear on his left hand	F 684	Immediate Corrective Action: R92□s skin was assessed and documented for accuracy IDT immediately re-educated on Pressure Injury/Skin Integrity/Wound Management policy Corrective action as it applies to others: Residents with known wound care were assessed for accuracy of assessments. Prevent recurrence: Policy for Pressure Injury/Skin Integrity/Wound Management reviewed and remains current. Licensed Nurses were re-educated on Pressure Injury/Skin Integrity/Wound Management policy Ongoing Monitoring: DON/Designee will audit TAR completion of 5 residents - Daily X 1 week - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 4/4/2022	

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F 684	Continued From page 23	F 684		

from a fall.

On 3/2/22, at 7:24 a.m. a dressing with "2-20 BB" written on it, was observed on the top of R92's left hand. R92 stated, "They haven't looked at it in a while".

On 3/2/22, at 7:42 a.m. registered nurse manager (RN-B) stated the dressing covered a skin tear and the wound had not been assessed since 2/20/22. RN-B stated he would have RN-E assess the area and change the dressing. Further, he would have the provider assess the wound during next visit.

On 3/2/22, at 7:55 a.m. RN-E entered R92's room, and with gloved hands removed the dressing leaving three skin closure strips in place. The skin tear measured approximately 4 cm x 1 cm. The site had no redness, swelling or odor. RN-E cleaned the site with normal saline, performed hand hygiene, donned new gloves, applied a new dressing, and dated and initialed the dressing.

On 3/2/22, at 1:24 p.m. RN-B stated the skin tear should have been assessed daily, per facility protocol, until the provider assessed and provided wound care orders. RN-B stated the skin tear should have been monitored at least weekly to assess for infection.

The facility's Pressure Injury/Skin Integrity/Wound Management policy, revised 11/2016, indicated daily and/or routine ongoing documentation should be conducted by the licensed nurse related to the resident's skin condition and the resident's response to the care and treatment of the skin. This includes non-pressure wounds as

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F 684	Continued From page 24 well.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess residents' risks for smoking independently for 1 of 4 residents (R69) reviewed for safe smoking. Findings include: R69's Admission Record, undated, indicated diagnoses of cognitive communication deficit, weakness and nicotine dependence. R69's admission minimum data set (MDS) dated 2/07/22, identified R69 was moderately cognitively impaired and required limited assistance with toileting and dressing. In further review of R69's Admission MDS, section J1300 indicated R69 was a smoker. According to R69's Admission Record, undated, was admitted to the facility on 1/28/22, 30 days prior to survey. During observation and interview, on 2/28/22, at 2:47 p.m. R69 had a pack of cigarettes laying on the bed next to him. R69 stated he smoked, and	F 689	Immediate Corrective Action: R69's care plan was assessed and updated for accuracy IDT immediately re-educated on Free of Accident/Hazards/Supervision/Devices IDT immediately was re-educated on Chris Jensen Health and Rehabilitations Smoking Policy Corrective action as it applies to others: All residents have been reviewed for the desire to participate in tobacco use Residents who smoke or who have expressed a desire to smoke have had a new smoking assessment completed to determine their smoking needs. Prevent recurrence: The Policy and procedure for Smoking has been reviewed and revised. The Policy and procedure for Free of Accident/Hazards/Supervision/Devices has been reviewed and remains current. Nursing staff were re-educated on Free of	4/4/22

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F 689	Continued From page 25 was going outside to the designated smoking area several times a day. In review of R69's medical record, both paper and electronic, R69's medical record lacked evidence resident had been comprehensively assessed to be able to smoke independently. During interview on 3/02/22, at 1:26 p.m. unit manager (RN)-A verified R69 was a current smoker and stated the facility failed to assess R69 for independent smoking. A review of the facility's policy, entitled: Smoking Policy, effective 1/06/22, indicated: Procedure section C - "Residents who smoke will be assessed by nursing for safety with smoking at the time of admission, quarterly, and with a change in condition. The Assessment will include physical, cognitive, mood, and behavior that may affect their ability to smoke without supervision."	F 689	Accident/Hazards/Supervision/Devices Nursing staff were re-educated on Chris Jensen Health and Rehabilitations Smoking Policy Ongoing Monitoring: DON/Designee will audit safe smoking, accuracy of most recent smoking assessment on 5 residents - Daily X 1 week - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 4/4/2022	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		4/4/22

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F 880	Continued From page 26 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 27 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 3 residents (R34) observed during personal cares. Finding include: R34's Diagnoses List printed on 3/3/22, identified dementia, muscle weakness, spondylois without myelopathy or radiculopathy lumbar region (degenerative changes of the discs and vertebral bodies which may be associated with low back pain). R34' quarterly Minimum Data Set (MDS) dated 1/6/22, indicated R34 had severe cognitive impairment and required extensive assistance with activities of daily living (ADLs). On 3/2/22, at 7:04 a.m. nursing assistant (NA)-C entered R34's room to get her up for the day. NA-C put on a pair of gloves and asked R34 what she wanted to wear, picked out clothing placed the clothing at the head of the bed, pulled the privacy curtain and undid R34's brief. R34 was	F 880	Immediate Corrective Action: R34□s was assessed for any adverse effect following the deficient practice DON and DON reviewed and acknowledged hand hygiene, hand washing, and glove usage to ensure they meet CDC guidance and CMS requirements. □ DPOC. IDT was immediately re-educated on Hand Hygiene, Hand Washing and Glove Usage. Corrective action as it applies to others: Infection prevention applies to all residents. Prevent recurrence: Hand Hygiene, Hand Washing, and Glove Usage Policies and Procedures were reviewed and remained current. All departments were re-educated on Hand Hygiene, Hand Washing and Glove Usage. Ongoing Monitoring: DON/Designee will audit Hand Hygiene	

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F 880	Continued From page 28 incontinent of urine. NA-C washed R34 front and back, rolling her side to side while telling R34 what she was doing, and using a new wipe for each area. NA-C finished getting R34 dressed with her soiled gloves told her she would be back with help to get her into her chair. NA-C then bagged up the linen and garbage wearing same soiled gloves. She took the linen and garbage to the shower room where she disposed of it in containers, and and then removed her soiled gloves. NA-C did not perform hand hygiene throughout the entire process. NA-C went to the desk and picked up her clip board. On 3/2/22, at 1:23 p.m. NA-C verified she had not performed any hand hygiene after performing cares for R34 and removing her gloves. On 3/3/221, at 9:25 a.m. registered nurse (RN)-C verified she expected staff to perform hand hygiene after removing gloves. On 3/3/21, at 10:29 a.m. the nurse consultant verified he expected staff to perform hand hygiene after removing gloves. The facility policy titled Hand Washing dated 4/1/08, directed staff to wash their hands after each direct resident contact for which hand washing was indicated by accepted professional practice. Hand-washing was also conducted as per recommendations from the CDC guidelines. The policy did not address hand hygiene and glove use.	F 880	and Glove Usage on 5 staff members - Shiftly X 7 days - Daily until 100% compliance is met. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Re-submission for DPOC - attachments placed in for DPOC. Date of compliance:4/4/2022	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions	F 921		4/4/22

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F 921	Continued From page 29 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain clean and sanitary conditions in 3 of 3 refrigerators (Spruce, Cedar, Elm) on nursing units in which resident food was stored. Findings include: During an observation on 3/3/22, at 8:48 a.m. Spruce unit's refrigerator temperature log was not available. Registered nurse (RN)-A stated the refrigerator was used to store resident food and the night shift was responsible for recording temperatures. RN-A was not sure where the temperature log was located. The sign on the refrigerator titled Refrigerator Reminders, directed night nursing staff to clean the refrigerator every Wednesday night. Refrigerator temperature logs were requested for the past three months. The facility failed to provide evidence of monitoring refrigerator temperatures for Spruce; December 2021, January and February 2022, During an observation on 3/3/22, at 8:53 a.m. Cedar unit's refrigerator had dried substances covering the bottom of the refrigerator. The refrigerator was used to store food for residents. There was a sign posted on the front of the refrigerator indicating nights were supposed to clean the refrigerator on Wednesday nights. RN-F verified the refrigerator was used to store resident food and not clean. She stated, "it	F 921	Immediate Corrective Action Not resident specific IDT was immediately re-educated on Refrigerator temperature Corrective action as it applies to others: All residents can be affected by Safe/Functional/Sanitary/Comfortable Environment All refrigerators were cleaned and reviewed for appropriate temperatures and assessed for cleanliness. Prevent recurrence: Policy and Procedure for Refrigeration Refrigerator Temperature was reviewed and revised. All departments were re-educated on Refrigerator temperature Foods will be consumed at appropriate temperatures in accordance with professional standards for food safety. Temperature logs on food refrigerators directs staff to call maintenance if refrigerator temperature is greater than 40 degrees and freezer is above 0 degrees. Ongoing Monitoring: DON/Designee will audit Refrigerator temperatures - Daily X 1 week - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	C 03/03/2022

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F 921	Continued From page 30 doesn't look like anyone cleaned it." RN-F was not able to locate a thermometer in the refrigerator or any temperature logs for the refrigerator. The sign on the refrigerator titled Refrigerator Reminders, directed night nursing staff to clean the refrigerator every Wednesday night. Refrigerator temperature logs were requested for the past three months. The Cedar unit's January refrigerator log had three temperatures recorded, all were above 41 degrees Fahrenheit (F). However, the facility was unable to provide evidence of monitoring refrigerator temperatures for December 2021, or February 2022. On 3/3/22, at 9:06 a.m. on the Elm nursing unit, the refrigerator temperature reading was 46 degrees F. RN-B verified the refrigerator was used to store food for residents. RN-B verified the temperature was too warm and something needed to be done about it. RN-B verified the refrigerator was too crowded. In the freezer there was a dried sticky substance, covering the front of the freezer floor. RN-B verified the freezer looked like it needed to be cleaned. The sign on the refrigerator titled Refrigerator Reminders, directed night nursing staff to clean the refrigerator every Wednesday night. Refrigerator temperature logs were requested for the past three months. The Elm unit's March refrigerator log had three temperatures recorded, all were below 41 degrees F. However, the facility was unable to provide monitoring of refrigerator temperatures for December 2021, or January 2022. Refrigerator temperature logs sheets included	F 921	Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 4/4/2022	

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F 921	Continued From page 31 direction of "Temperature for medication refrigerator should be between 36 degrees F and 46 degrees F, all others should be 40 degrees F or below. If temperature is not adequate, adjust or notify appropriate individuals for repair, and remove contents to another refrigerator for storage." On 3/3/22, at 10:33 a.m. the nurse consultant verified refrigerators with resident food needed to have the temperatures monitored, needed to be kept clean, and if temperatures were out of range staff should contact maintenance and follow the policy. The facility policy, not titled or dated, indicated refrigerator temperatures needed to be under 40 degrees F. The policy further indicated temperatures should be checked and logged daily. In addition the policy directed staff to not crowd items in the refrigerator for air circulation.	F 921		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245366	A. BUILDING: _____ B. WING _____	3/3/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CEN	**2501 RICE LAKE ROAD DULUTH, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the resident or their representative a written bed hold notice for 2 of 2 residents (R54, R79) reviewed for hospitalization. Finding include: R54's Diagnosis Report printed on 3/3/22, indicated diagnoses of chronic respiratory failure with hypoxia (low oxygen saturations), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), dementia, chronic diastolic heart failure (a condition in which the heart does not pump blood effectively), and muscle weakness. On 3/1/22, at 3:24 p.m. R54 was observed being transported to the hospital by Mayo ambulance service. On 3/2/22, at 8:48 a.m. registered nurse (RN)-C stated she forgot to complete a bed hold on 3/1/22, when R54 went to the hospital. RN-C verified R4 had also had an unplanned hospitalization on 1/27/22. RN-C looked for evidence of a bed hold being completed on 1/27/22, but was unable to find one. RN-C stated R54 was a long term resident and it was assumed she would want to come back. RN-C stated she was going to complete a bed hold for R54 for the transfer on 3/1/22. R79's Minimum Data Set (MDS), dated 11/18/21, indicated diagnoses included anemia, hyponatremia, and viral hepatitis. MDS was completed on 1/10/22 indicating R79 had an unplanned discharge from the facility but was expected to return. On 1/13/22 an entrance MDS was completed.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Continued From Page 1

R79's progress note, 1/10/22 at 1:09 p.m. noted an order was received to send R79 to the hospital for evaluation related to lab results.

R79's progress notes dated 1/9/22-1/12/22 and clinical record lacked evidence that either R79 or R79's representative was informed of the bed hold policy at the time of transfer.

On 3/3/22, at 10:30 a.m. the nurse consultant verified he would have expected staff to complete the bed hold process.

On 3/1/22, at 1:24 p.m. the Administrator stated she expected the nurse transferring the resident to complete the bed hold form or get verbal consent.

The facility policy Bed Hold and Re-Admission dated 5/2020, directed staff before a resident was transferred or placed on a therapeutic leave, written notification was provided to the resident, and/or resident representative.

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted on 03/01/2022, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Chris Jensen Health and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/23/2022

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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K 000	Continued From page 1 CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Chris Jensen Health and Rehabilitation Center is a 2-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1974 & 1985 an additions were constructed to the building that were determined to be of Type	K 000		

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K 000	Continued From page 2 II(111) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 170 beds and had a census of 112 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain exit discharge paths per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code sections 19.2.7, 7.7.1.1, and 7.3.4.1 (2). These deficient findings could have a pattered	K 271	7.3.4.1 (2) The width of any areas of egress, unless otherwise provided in 7.3.4.1.1 through 7.3.4.1.3 shall be as follows: (1) Not less than required for a given egress component in this chapter or	3/21/22

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K 271	Continued From page 3 impact on the residents within the facility. Findings Include: 1. On 03/01/2022 at 1:00 PM, it was revealed by observation that the exit discharge path from the exit located by resident room E127 in the Elm Wing had sections of snow cover of up to 3 inches obstructing the full and clear egress from the building. 2. On 03/01/2022 at 1:00 PM, it was revealed by observation that the exit discharge path from the exit located by resident room E127 in the Elm Wing did not have a hard packed path to the public way. 3. On 03/01/2022 at 1:50 PM, it was revealed by observation that the exit discharge path from the exit located in the Birch Wing had sections of snow cover of up to 3 inches obstructing the full and clear egress from the building. 4. On 03/01/2022 at 1:50 PM, it was revealed by observation that due to the sections of snow cover on the exit discharge path that it could not be verified if the Birch Wing exit discharge that leads around the facility and towards the main parking lot has a hard packed path to the public way. 5. On 03/01/2022 at 1:50 PM, it was revealed by observation that the width of the exit discharge path located at the Birch Wing exit discharge that leads around the facility and towards the main parking lot that had sections of snow removed did not create a continuous discharge path that measured at least 36 inches wide.	K 271	Chapters 11 through 43 (2) Not less than 36 in (915 mm) where another part of this chapter and chapters 11 through 43 do not specify a minimum width 7.7.1.1 Yards, courts, open spaces or other portions of the exit discharge shall be of the required width and size to provide all occupants with a safe access to a public way. Corrective Action: IDT immediately re-educated on the criteria for Discharge from Exits IDT immediately re-educated on notifying designee of any potential issues Deficient practices were fixed to meet Life Safety Codes Quote for a hard packed pathway from the exit located on Elm and Birch has been obtained. Extension request from fire Marshall attached. Sidewalks will be completed as weather and/or contractors allows. Identification of other Residents: All residents could be impacted by Discharge from Exits Monitoring Mechanism: ED/Designee will audit the Discharge from Exits - Daily X 1 week - 5 times per week X 2 weeks - 2 times per week X 4 weeks	

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K 271	Continued From page 4 An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 271	Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. New waiver submitted. Date of compliance: 3/21/2022	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 321		3/21/22

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K 321	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code, section 19.3.2.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 03/01/2022 at 1:55 PM, it was revealed by observation that the door to the soiled utility room located in the Birch Wing did not fully close and positively latch into the frame. 2. On 03/01/2022 at 1:55 PM, it was revealed by observation that the soiled utility room located in the Birch Wing has damage spanning from the latching mechanism to the bottom of the door and is no longer smoke resistant. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 321	19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1 19.3.2.1.3 The doors shall be self-closing or automatic closing. Corrective Action: IDT immediately re-educated on the criteria for Hazardous Areas IDT immediately re-educated on notifying designee of any potential issues Quote for a replacement fire door on Birch Soiled Utility Room has been obtained and will be installed upon arrival. Identification of other Residents: All residents could be impacted by Hazardous Areas Monitoring Mechanism: ED/Designee will audit 20 Fire Doors - Daily X 1 week - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 2 weeks Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Individual waiver submitted. Date of compliance: 3/21/2022	

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K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that the semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), section 9.2.3 and the 2011 edition of National Fire	K 324	9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for ventilation control and fire protection of commercial cooking operations, unless such installations are approved existing installations, which shall be permitted to be continued in service.	3/24/22

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K 324	Continued From page 7 Protection Association (NFPA) Standard 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.5. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 03/01/2022 at 11:20 AM., during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Maintenance Supervisor, the facility could not provide completed test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 324	Corrective Action: ED/DON/Maintenance Director/EVS Director/Culinary Director immediately re-educated on the criteria for Cooking Facilities Deficient practices were recognized Fire-X on-site to complete report Identification of other Residents: All residents could be impacted by Cooking Facilities Monitoring Mechanism: ED/Designee will audit the Cooking Facilities - Semi-annually X 2 Years Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 3/24/2022	
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced	K 345		3/22/22

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	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 8 by: Based on observations and staff interview, the facility failed to maintain the fire alarm system per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), section 9.6.1.3, and the 2010 edition of National Fire Protection Association (NFPA) Standard 72 National Fire Alarm and Signaling Code, section 14.5.1. This deficient finding could have an isolated impact on the residents within the facility Findings include: On 03/01/2022, at 1:40 PM, it was revealed by observation during the facility tour that the smoke detector that is located within the Spruce Wing Dining room was covered with rust, calcification and some kind of plaster like substance that was building up on the detector head from a water leak in the ceiling. The build up of this debris is reducing / restricting the opening to the smoke chamber of the detector head. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 345	9.6.1.3 A fire alarm system required for life safety shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 70, National electric code and NFPA 72, National fire alarm and signaling code, unless it is an approved existing installation, which shall be permitted to be continued in use. Corrective Action: ED/DON/Maintenance Director/EVS Director immediately re-educated on the criteria for Testing and Maintenance Deficient practices were identified, and ESC has been on-site and completed. Identification of other Residents: All residents could be impacted by Fire Alarm System – Testing and Maintenance Monitoring Mechanism: ED/Designee will audit 5 Smoke Alarms - 5 times per week X 2 weeks - 2 times per week X 4 weeks - Weekly X 2 weeks Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 3/22/2022	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING	K 351		3/21/22

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K 351	Continued From page 9 Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to install and maintain the fire sprinkler system per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), sections 8.3.5.6.3(3) and 9.7.1.1, and the 2010 edition of National Fire Protection Association (NFPA) Standard 13, Standard for the Installation of Sprinkler Systems, sections 6.2.7 and 8.16.1.1.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/01/2022 at 12:20 PM, it was revealed by observation that the fire sprinkler head located in the Birch Wing activities room is missing an escutcheon ring on the sprinkler head located next to the door.	K 351	Where walls or partitins are required to have a minimum 1 hour fire resistance rating, recessed fixtures shall be installed in the wall or prtition in such a manner that the required fire resistance is not reduced, unless one of the following is met: (3) The annular space created by the membrane penetration of a fire sprinkler shall be permitted provided that the space is covered by a metal escutcheon plate. 9.7.1.1 Each automatic sprinkler system required by another section of this code shall be in accordance with one of the following: (1) NFPA 13 Standard for the installation of sprinkler systems (2) NFPA 13D Standard for the installation of sprinkler systems in one and two family dwellings and manufactured Homes	

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K 351	Continued From page 10 An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 351	(3) NFPA 13R Standard for the installation of sprinkler systems in residential occupancies up to and including four stories in height Corrective Action: ED/DON/Maintenance Director/EVS Director immediately re-educated on the criteria for Sprinkler System Deficient practices were corrected to meet the Life Safety Statute Audit of entire building sprinkler heads on 3/18/2022. Identification of other Residents: All residents could be impacted by Sprinkler System - Installation Monitoring Mechanism: ED/Designee will audit 10 Sprinkler Heads - 5 times per week X 4 weeks - 2 times per week X 4 weeks - Weekly X 2 weeks Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 3/21/2022	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		3/21/22

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	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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K 353	Continued From page 11 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review, and staff interview, the automatic sprinkler system is not maintained per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code, section 9.7.5, and the 2011 edition of National Fire Protection Association (NFPA) Standard 25, the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, sections 5.1.1.2, 5.3.2.1, and 5.4.1.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/01/2022, at 12:52 PM, it was revealed by observation that there are 15 unsecured fire sprinkler heads that were not protected from being damaged, stored within the spare sprinkler head box that is located at the main fire sprinkler riser in the upper boiler room.	K 353	9.7.5 Maintenance & Testing. All automatic sprinkler and standpipe systems required by this code shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, testing and maintenance of water based fire protection systems Corrective Action: ED/DON/Maintenance Director/EVS Director immediately re-educated on the criteria for Sprinkler System – Maintenance and Testing Deficient practices were identified, new Sprinkler Head Storage box has been ordered with a confirmation of arriving in 1-2 weeks from 03/15/2022. Identification of other Residents: All residents could be impacted by Sprinkler System – Maintenance and Testing	

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K 353	Continued From page 12 An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 353	Monitoring Mechanism: ED/Designee will audit Sprinkler Storage Box once installed - 5 times per week X 1 week - 2 times per week X 2 weeks - Weekly X 2 weeks Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 3/21/2022	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, it was determined that the facility failed to maintain portable fire extinguishers per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code, sections 9.7.4.1, 19.3.5.12, and the 2010 edition of National Fire Protection Association (NFPA) Standard 10, Standard for Portable Fire Extinguishers, sections 7.2.4.5, 7.3.1.1.1, and 7.3.1.1.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include:	K 355	9.7.4.1 Where required by the provisions of another section of this code, portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10 Standard for portable fire extinguishers. 19.3.5.12 Portable Fire Extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1 Corrective Action: ED/DON/Maintenance Director/EVS Director immediately re-educated on the	3/21/22

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K 355	Continued From page 13 1. On 03/01/2022 at 1:17 PM, it was revealed by observation that the maintenance record tag that is attached to the fire extinguisher located by resident room W106 did not annotate what year the extinguisher had been annually inspected. 2. On 03/01/2022 at 1:17 PM, it was revealed by observation that the maintenance record tag that is attached to the fire extinguisher located by resident room W106 did not have 6 of 12 monthly inspections annotate on the tag. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 355	criteria for Portable Fire Extinguisher – Maintenance Record Tag Deficient practices were corrected to meet the Life Safety Statute Identification of other Residents: All residents could be impacted by Portable Fire Extinguisher Monitoring Mechanism: ED/Designee will audit Portable Fire Extinguisher Log - 5 times per week X 1 week - 2 times per months X 1 month - Monthly X 1 year Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 3/21/2022	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.	K 363		3/23/22

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K 363	Continued From page 14 Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility had 2 of numerous corridor doors that did not meet the requirements per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code, sections 19.3.6.3 and 19.3.6.3.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 03/01/2022, at 12:56 PM, it was revealed by observation that that the corridor door of resident	K 363	19.3.6.3.1 Doors Protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed of materials such as the following: (1) 1 ¾" thick solid bonded core wood (2) Material that resists fire for a minimum of 20 minutes. Corrective Action: ED/DON/Maintenance Director/EVS Director immediately re-educated on the criteria for Corridor Doors – Latching	

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K 363	Continued From page 15 room E100 in the Elm Wing did not positively latch into the door frame. On 03/01/2022, at 1:51 PM, it was revealed by observation that that the corridor door of resident room B120 in the Birch Wing did not positively latch into the door frame. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 363	Deficient practices were corrected to meet the Life Safety Statute Identification of other Residents: All residents could be impacted by Corridor - Doors Audit of all other doors for latching has been completed. Monitoring Mechanism: ED/Designee will audit 5 Corridor Doors - Latching - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 3/23/2022	
K 364 SS=D	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In	K 364		3/21/22

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K 364	Continued From page 16 fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility had 2 of numerous corridor doors that did not meet the requirements per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code, sections 19.3.6.4.1 and 19.3.6.4.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/01/2022, at 1:20 PM, it was revealed by observation that there are two of the corridor doors to the nurse's offices located in the Willow Wing had transfer grills located in them. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 364	19.3.6.4.1 Transfer grills regardless of whether they are protected by fusible link-operated dampers shall not be used in corridor walls or doors. Corrective Action: ED/DON/Maintenance Director/EVS Director immediately re-educated on the Corridor - Openings Deficient practices were identified and a quote for new Corridors has been obtained. Will be installed upon arrival. Identification of other Residents: All residents could be impacted by Corridor - Openings Monitoring Mechanism: ED/Designee will audit 5 Corridor Doors □ Openings - 5 times per week X 1 week - 2 times per week X 4 weeks Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Individual waiver submitted. Date of compliance: 3/21/2022	
K 712 SS=F	Fire Drills	K 712		3/21/22

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K 712	Continued From page 17 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code , sections 19.7.1.2 and 19.7.1.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/01/2022, at 10:50 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct an overnight shift fire drill in the first and third calendar quarters. 2. On 03/01/2022, at 10:50 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct an evening shift fire drill in the third calendar quarter.	K 712	Corrective Action: IDT immediately re-educated on the criteria for Fire Drills IDT immediately re-educated on notifying designee of any potential issues Deficient practices were fixed to meet Life Safety Codes Calendar for Fire Drills created to ensure all shifts experience a drill. Identification of other Residents: All residents could be impacted by Discharge from Exits Monitoring Mechanism: ED/Designee will audit Fire Drill log Monthly X 1 year Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 3/21/2021	

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K 712	Continued From page 18 An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 712		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per the 2012 edition of National Fire Protection Association (NFPA) Standard 99, The Health Care Facilities Code, section 4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/01/2022, at 11:12 AM, during a review of available documentation and an interview with Maintenance Supervisor, it was revealed that the facility provided a utility risk assessment document that did not contain a complete list of the specific facility systems from NFPA 99	K 901	K901 4.1 Fire. A goal of this code is to provide an environment for occupants that is reasonably safe from fire by the following means: (1) Protection of occupants not intimate with the initial fire development (2) Improvement of the survivability of occupants intimate with the initial fire development Corrective Action: ED/DON/Maintenance Director/EVS Director immediately re-educated on the criteria Building System Categories – Utility Risk Assessment New Utility Risk Assessment was	4/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	**2501 RICE LAKE ROAD** **DULUTH, MN 55811**

(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
K 901	Continued From page 19 chapters 6 and 9 of the 2012 edition of NFPA 99, The Health Care Facilities Code and the related room categories and the correct risk assessments for the rooms within the facility. 2. On 03/01/2022, at 11:12 AM, during a review of available documentation and an interview with Maintenance Supervisor, it was revealed that the facility provided a utility risk assessment document that did not contain a complete list of the electrical and gaseous patients/residents care equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of NFPA 99, The Health Care Facilities Code chapters 10 and 11. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 901	completed to correct deficient Life Safety Practice Identification of other Residents: All residents could be impacted by Fundamentals – Building System Categories Monitoring Mechanism: ED/Designee will audit and verify completion and accuracy of Utility Risk Assessment - 2 times per month X 2 months - Verifying Completion and Accuracy Monthly X 1 year. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 4/1/2022	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this	K 914		3/21/22

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K 914	Continued From page 20 manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to complete the annual electrical outlet testing and maintenance per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/01/2022, at 11:49 AM, during the review of all available electrical outlet maintenance and testing documentation and an interview with the Maintenance Supervisor, it was revealed that the facility had failed to complete the annual inspection of the outlets located within the patient/resident care areas for 48 of 124 rooms within the last 12 months. An interview with the Maintenance Supervisor verified this deficient finding at the time of the discovery.	K 914	6.3.4.1.3 Receptacle not listed as hospital grade at patient bed locations and in locations where deep sedation or general anesthesia is administered shall be tested at intervals not exceeding 12 months Corrective Action: ED/DON/Maintenance Director/EVS Director immediately re-educated on the criteria for Electrical Systems – Maintenance and Testing Deficient practices were corrected by completing an annual inspection to meet the Life Safety Statute Identification of other Residents: All residents could be impacted by Electrical Systems – Maintenance and Testing All outlets audited to ensure Life safety statute is up to date. Monitoring Mechanism: ED/Designee will audit Electrical Systems – Maintenance and Testing log to ensure timely inspections - 5 times per week X 1 week - 2 times per months X 1 month	

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	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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K 914	Continued From page 21	K 914	- Monthly X 1 year Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 3/21/2022	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		3/22/22

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K 918	Continued From page 22 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code, sections, 9.1.3, and the 2010 edition of National Fire Protection Association (NFPA) Standard 110, Standard for Emergency and Standby Power Systems, section 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/01/2022, at 11:40 AM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Maintenance Supervisor, that the facility could not provide 2 of 12 monthly emergency generator test and inspection documentation. 2. On 03/01/2022, at 11:40 AM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Maintenance Supervisor, that the facility could not provide 8 of 52 weekly emergency generator inspection documentation. An interview with the Maintenance Supervisor verified these deficient findings at the time of	K 918	9.1.3 Emergency Generators and standby power systems. Where required for compliance with this code emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2 Corrective Action: ED/DON/Maintenance Director/EVS Director immediately re-educated on the criteria for Electrical Systems – Essential Electric Systems Deficient practices were corrected to meet the Life Safety Statute Audited current Generator logs Identification of other Residents: All residents could be impacted by Electrical Systems – Essential Electric Systems Monitoring Mechanism: ED/Designee will audit Generator inspection logs - Weekly times 1 year Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance. Date of compliance: 3/22/2022	

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K 918	Continued From page 23 discovery.	K 918		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 15, 2022

Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: 1UWU11

Dear Administrator:

The above facility was surveyed on February 28, 2022 through March 3, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 Nursing Homes.

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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@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
	00598	A. BUILDING: _____ B. WING _____	C 03/03/2022

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CHRIS JENSEN HEALTH & REHABILITATION C	2501 RICE LAKE ROAD DULUTH, MN 55811

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, 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 indicated below. When a rule 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. INITIAL COMMENTS: On February 28, 2022 through March 3, 2022, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 0540, 0860, 1015, 1426, and 1695.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5366272C (MN80194), H5366274C (MN79484), H5366277C (MN81221), H5366278C (MN81294), H5366279C (MN81223), H5366280C (MN81417), with no licensing order issued. The following complaints were found to be UNSUBSTANTIATED: H5366271C (MN80406), H5366273C (MN79851), H5366275C (MN79435), H5366276C (MN79207). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 2 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior	2 540		4/4/22

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2 540	Continued From page 3 medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess residents' risks for smoking independently for 1 of 4 residents (R69) reviewed for smoking. Findings include: R69's Admission Record, undated, indicated diagnoses of cognitive communication deficit, weakness and nicotine dependence. R69's admission minimum data set (MDS) dated 2/07/22, identified R69 was moderately cognitively impaired and required limited assistance with toileting and dressing. In further review of R69's Admission MDS, section J1300 indicated R69 was a smoker. According to R69's Admission Record, undated, was admitted to the facility on 1/28/22, 30 days prior to survey. During observation and interview, on 2/28/22, at 2:47 p.m. R69 had a pack of cigarettes laying on	2 540	Completed.	

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2 540	Continued From page 4 the bed next to him. R69 stated he did smoked, and was going outside to the designated smoking are several times of the day. In review of R69's medical record, both paper and electronic, R69's medical record lacked evidence resident had been comprehensively assessed to be able to smoke independently. During interview on 3/02/22, at 1:26 p.m. unit manager (RN)-A verified R69 was a current smoker and stated the facilty failed to assess R69 for independent smoking. A review of the facility's policy, entitled: Smoking Policy, effective 1/06/22, indicated: Procedure section C - "Residents who smoke will be assessed by nursing for safety with smoking at the time of admission, quarterly, and with a change in condition. The Assessment will include physical, cognitive, mood, and behavior that may affect their ability to smoke without supervision." SUGGESTED METHOD FOR CORRECTION: The Director of Nurses (DON) could review and revise policies and procedures for conducting comprehensive assessments and provide additional training to involved staff. A designated staff could monitor the system to assure assessments are complete and accurate. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 540		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining	2 860		4/4/22

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2 860	Continued From page 5 adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure nail care was provided to 1 of 4 residents (R35) whom were dependent upon staff for activities of daily living (ADL's). Findings include: R35's quarterly Minimum Data Set (MDS) dated 1/6/22, indicated R35 required assistance from another person for ADLs including personal hygiene. R35 was not able to communicate his needs. R35's face sheet, printed 3/2/22, noted diagnoses included neurological injury. R35's care plan, undated, indicated R35 required assist from one staff for hygiene. On 3/2/22, at 11:08 a.m. R35 was observed to have 1/4-inch-long fingernails on both hands. Both hands had fingers wrapped around a washcloth. The fingernails on the third and fourth fingers of each hand were pressing on the palms of his hands. No redness was noted where the nails were pressing. On 3/2/22, at 1:33 p.m. nursing assistant (NA)-B stated fingernails were supposed to be trimmed on R35's bath day (Wednesday) and as needed. NA-B confirmed R35's fingernails were long and	2 860	Completed.	

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CHRIS JENSEN HEALTH & REHABILITATION C	2501 RICE LAKE ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 860	Continued From page 6 likely not trimmed on his last bath day (2/23/22). NA-B stated R35 does not resist nail care. On 3/2/22, at 1:45 p.m. registered nurse (RN)-A confirmed R35's nails were long and the nails on the third and fourth fingers of each hand, were pressing on the palms of his hands, and the length of R35's nails was more than a week's worth of growth. RN-A stated she expected nail care, including trimming, was done on the resident's bath day, and as needed. RN-A stated R35 was at risk for scratching himself with long nails and pressure injury because of the nails pressing into the palms of his hands. Facility policy, Nail Care, dated 4/1/08, indicated the procedure for nail care included fingernails are trimmed weekly during bathing or more often, if necessary. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could insure that staff are re-in serviced as to their responsibility to provide dependent residents with assistance with nail care according to facility policy. The Director of Nursing could conduct audits to ensure the care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most	21426		4/4/22

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	00598	A. BUILDING: _____ B. WING _____	C 03/03/2022

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21426	Continued From page 7 current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure initial tuberculosis (TB) skin testing (TST) had been completed for 3 of 5 employees (NA-F, NA-G, NA-H and DA-A) who were reviewed for TB screening. Furthermore, the facility failed to ensure TB skin testing and symptom screening for 3 of 5 residents (R35, R315 and R362) who were reviewed for TB screening. Findings include: The facility provided a listing of new hires for the last 4 months, with their start dates. Survey randomly selected two full time and 3 part-time employees for review of the facility TB screen / testing protocols.	21426	Completed.	

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21426	Continued From page 8 EMPLOYEE: Nursing assistant (NA)-F was hired 1/31/22. A review of NA-F's employee record lacked evidence that a second TST skin test had been given. NA-G was hired 1/10/22. A review of NA-G's employee record lacked evidence that a second TST skin test had been given. NA-H was hired 1/24/22. A review of NA-H's record lacked evidence employee was ever given a TST (neither Step 1 or Step 2 were documented). RESIDENT: R35's Admission Record indicated R35 was admitted 3/22/21. R35's medical record lack evidence R35 had ever been screened for signs and symptoms of TB, nor skin tested for the presence of the TB virus. During the time R35 was admitted, there was a Centers of Medicare / Medicare Services (CMS) and Health and Human Services waiver which waved the TB screening and skin testing during the COVID Pandemic. This waiver ended March 31st, 2021. It was the expectation after that date, regular TB screening and TB skin testing would resume. R315's Admission Record indicated R315 was admitted 2/11/22. Although R315's medical record had documentation a TB symptom screen had been completed, R315 lacked evidence of resident receiving any skin testing for TB. R362's Admission Record indicated R362 was	21426		

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21426	Continued From page 9 admitted 2/15/22. R362's medical record lack evidence R362 had received a Step 2 (second skin test). During an interview on 3/03/22, at 10:24 a.m., the infection preventionist (RN)-B was unable to find the missing information and did further investigation. At 12:47 p.m., RN-B stated the information which had been provided was all the facility had. RN-B stated all staff should be tested before resident contact, and all residents should be tested before or at the time of their admission for TB. In a review of the facility's TB Risk Assessment (last revised 4/13/21) indicated the facility was at "LOW" risk for the transmission of TB. The protocol of this risk assessment indicated both staff and residents were to receive two separate skin tests and have been screened for signs and symptoms of TB.	21426		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain clean and sanitary conditions in 3 of 3 refrigerators (Spruce, Cedar, Elm) on nursing units in which resident food was stored. Findings include:	21665	Completed	4/4/22

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21665	Continued From page 10 During an observation on 3/3/22, at 8:48 a.m. Spruce unit's refrigerator temperature log was not available. Registered nurse (RN)-A stated the refrigerator was used to store resident food and the night shift was responsible for recording temperatures. RN-A was not sure where the temperature log was located. The sign on the refrigerator titled Refrigerator Reminders, directed night nursing staff to clean the refrigerator every Wednesday night. Refrigerator temperature logs were requested for the past three months. The facility failed to provide evidence of monitoring refrigerator temperatures for Spruce; December 2021, January and February 2022, During an observation on 3/3/22, at 8:53 a.m. Cedar unit's refrigerator had dried substances covering the bottom of the refrigerator. The refrigerator was used to store food for residents. There was a sign posted on the front of the refrigerator indicating nights were supposed to clean the refrigerator on Wednesday nights. RN-F verified the refrigerator was used to store resident food and not clean. She stated, "it doesn't look like anyone cleaned it." RN-F was not able to locate a thermometer in the refrigerator or any temperature logs for the refrigerator. The sign on the refrigerator titled Refrigerator Reminders, directed night nursing staff to clean the refrigerator every Wednesday night. Refrigerator temperature logs were requested for the past three months. The Cedar unit's January refrigerator log had three temperatures recorded, all were above 41 degrees Fahrenheit (F). However, the facility was unable to provide	21665		

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21665	Continued From page 11 evidence of monitoring refrigerator temperatures for December 2021, or February 2022. On 3/3/22, at 9:06 a.m. on the Elm nursing unit, the refrigerator temperature reading was 46 degrees F. RN-B verified the refrigerator was used to store food for residents. RN-B verified the temperature was too warm and something needed to be done about it. RN-B verified the refrigerator was too crowded. In the freezer there was a dried sticky substance, covering the front of the freezer floor. RN-B verified the freezer looked like it needed to be cleaned. The sign on the refrigerator titled Refrigerator Reminders, directed night nursing staff to clean the refrigerator every Wednesday night. Refrigerator temperature logs were requested for the past three months. The Elm unit's March refrigerator log had three temperatures recorded, all were below 41 degrees F. However, the facility was unable to provide monitoring of refrigerator temperatures for December 2021, or January 2022. Refrigerator temperature logs sheets included direction of "Temperature for medication refrigerator should be between 36 degrees F and 46 degrees F, all others should be 40 degrees F or below. If temperature is not adequate, adjust or notify appropriate individuals for repair, and remove contents to another refrigerator for storage." On 3/3/22, at 10:33 a.m. the nurse consultant verified refrigerators with resident food needed to have the temperatures monitored, needed to be kept clean, and if temperatures were out of range staff should contact maintenance and follow the policy.	21665		

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21665	Continued From page 12 The facility policy, not titled or dated, indicated refrigerator temperatures needed to be under 40 degrees F. The policy further indicated temperatures should be checked and logged daily. In addition the policy directed staff to not crowd items in the refrigerator for air circulation. A SUGGESTED METHOD FOR CORRECTION: The administrator and the dietary manager could review and revise food service policies and procedures to assure the refrigerators are maintained in a sanitary manner. Staff could be trained as necessary and a cleaning schedule developed. The dietary manager could monitor the cleanliness of the refrigerators on a regularly basis. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to clean and maintain wheelchairs for 3 of 3 residents (R10, R34, R50) reviewed for dirty wheelchairs.	21695	Completed	4/1/22

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21695	Continued From page 13 Findings include: R10 was observed on 3/2/22, at 8:39 a.m. eating on her own with her fingers, dropping food onto her lap and wheelchair. On 3/2/22, at 1:37 p.m. nursing assistant (NA)-D stated the wheelchairs on the unit were "pretty dirty". NA-D stated R10's and R34's were wheelchairs that needed to be cleaned. NA-D stated someone on the night shift used to clean the wheelchairs on the unit. NA-D was unsure about how wheelchairs were currently getting cleaned. On 3/2/22, at 3:00 p.m. R10 was seated in her wheelchair in the day room with family. Dried, raised white/yellow substances were noted on the side of her wheelchair, with white/yellow crusted matter down the metal side of the wheelchair in an area about three inches by four inches. There was dried white matter on both armrests of the wheel chair. On 3/2/22, at 3:05 p.m. NA-E verified the presence of the dried substances on R10's wheelchair stating, "that's not right, we need to get that cleaned up." On 3/2/22, at 7:04 a.m. nursing assistant (NA)-C assisted R34 with cares. R34's Broda chair was along the wall and had several dried white spots on the left side of the seat, the inside of both arm rests, and on the top of the left arm rest. There were several brown spots on the foot rest. NA-C verified the Broda chair looked dirty and said someone on nights used to go around and clean the chairs. NA-C volunteered that almost everyone's chair should be cleaned.	21695		

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21695	Continued From page 14 R50's wheelchair was observed on 2/28/22, at 2:56 p.m. to have several white splatters on the wheels, and arm rests approximately 2 inches round. Several long, white streaks were observed on the side panels, both inside and outside of the wheelchair. A large dried, unidentified substance, was noted on the right brake and brake handle. On 3/3/22, at 8:10 a.m. R50's wheelchair was observed, unchanged from the above observation. On 3/3/22, at 8:27 a.m. nursing assistant (NA)-H confirmed the appearance of R50's wheelchair. NA-H stated she was not aware if there was a schedule for wheelchair cleaning. Staff were to notify housekeeping when a wheelchair needed to be cleaned. On 3/3/22, at 8:59 a.m. registered nurse (RN)-C stated there was no one assigned to clean wheelchairs. However, if staff see it dirty, they are supposed to clean it. RN-C stated she did not know the last time R50's wheelchair had been cleaned. On 3/3/22, at 9:28 a.m. registered nurse (RN)-C stated the wheelchairs used to be cleaned on the night shift, however, the staff had not been able to clean wheelchairs. RN-C verified there was not a current procedure in place to clean wheelchairs. RN-C verified she expected staff to clean a wheelchair if it was brought to their attention. RN-C was not sure when the last time R10's wheelchair had been cleaned. On 3/3/22, at 9: 47 a.m. the maintenance director verified there was a wheelchair washer in the facility and the director of environmental services (EVS) was going to re-initiate a wheelchair	21695		

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21695	Continued From page 15 washing procedure, however, there was not an active procedure in place. On 3/3/22, at 9:51 a.m. EVS stated the wheelchair washer needed to be repaired and had no records of wheelchairs being washed. On 3/3/22, at 10:31 a.m. the nurse consultant (NC) verified wheelchairs should be cleaned regularly and he expected staff to clean a wheelchair when it appeared dirty. The facility policy titled Wheelchair Washing, Preventative Maintenance and Repair dated 3/3/06, directed nursing staff to wipe down wheelchairs as needed and to remove any food particles or spilled liquids. In addition the policy directed environmental staff to run the wheelchairs through the wheelchair washer on a scheduled, rotational basis, with one wings wheelchairs to be washed weekly. The policy directed environmental services to keep a log sheet of wheelchairs that were cleaned. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident equipment is cleaned timely. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		