#### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 55P9 Facility ID: 00598

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245366  2.STATE VENDOR OR MEDICAID NO. (L2) 175040200  5. EFFECTIVE DATE CHANGE OF OWNERSHIP	3. NAME AND ADDRESS OF FACILITY (L3) CHRIS JENSEN HEALTH & REHA (L4) 2501 RICE LAKE ROAD (L5) DULUTH, MN  7. PROVIDER/SUPPLIER CATEGORY	(L6) 55811 02 (L7)	4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
(L9) 11/01/2009 6. DATE OF SURVEY 10/22/2018 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	01 Hospital         05 HHA         09 ESRD           02 SNF/NF/Dual         06 PRTF         10 NF           03 SNF/NF/Distinct         07 X-Ray         11 ICF/II           04 SNF         08 OPT/SP         12 RHC	13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE	8. Full Survey After Complaint  FISCAL YEAR ENDING DATE: (L35)  12/31
11LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12.Total Facility Beds       170 (L18)         13.Total Certified Beds       170 (L17)	10.THE FACILITY IS CERTIFIED AS:  X A. In Compliance With  Program Requirements  Compliance Based On: 1. Acceptable POC  B. Not in Compliance with Program  Requirements and/or Applied Waivers:	And/Or Approved Waivers Of Th  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SNF  5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN         18 SNF       18/19 SNF       19 SNF         170       (L37)       (L38)       (L39)         16. STATE SURVEY AGENCY REMARKS (IF APPLICATED)	ICF IID (L42) (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE  Teresa Ament, Unit Supervis	(L19)	18. STATE SURVEY AGENCY A	rcement Specialist 11/02/2018 (L20)
PART II - TO E  19. DETERMINATION OF ELIGIBILITY  X 1. Facility is Eligible to Participate  2. Facility is not Eligible  (L21)	20. COMPLETED BY HCFA REGIONA 20. COMPLIANCE WITH CIVIL RIGHTS ACT:	21. 1. Statement of Finan	cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
A. Suspens		26. TERMINATION ACTION:  VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety nt 06-Fail to Meet Agreement
28. TERMINATION DATE: (L28)	(L45) 29. INTERMEDIARY/CARRIER NO. 03001 (L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE 10/03/2018 (L33)	DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245366

November 2, 2018

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 October 2, 2018 the above facility is certified for:

170 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 170 skilled nursing facility beds.

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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 1, 2018

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

RE: Project Number S5366029

Dear Administrator:

On September 10, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 23, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 22, 2018, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 23, 2018. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on August 23, 2018.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the August 23, 2018 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 23, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 23, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 23, 2018. You should notify

all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Chris Jensen Health & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 23, 2018. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

#### **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 <a href="https://dab.efile.hhs.gov">https://dab.efile.hhs.gov</a> 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.

## 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 February 23, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### **INFORMAL DISPUTE RESOLUTION**

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

> Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 2, 2018

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

RE: Project Number S5366029

Dear Administrator:

On November 1, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey completed on September 22, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 1, 2018, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 22, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 2, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 22, 2018, effective October 2, 2018 and therefore remedies outlined in our letter to you dated September 10, 2018, will not be imposed.

As a result of the PCR findings, this Department also recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following action related to the remedy outlined in our letter of November 1, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of the action:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 23, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 23, 2018 is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 23, 2018 is to be rescinded.

In our letter of November 1, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from

conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 23, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 2, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

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

DEPARTMENT OF HEALTH AND HUMAN	SERVICES	CENTERS FOR ME	EDICARE & MEDICAID SERVICES
MEDIO	CARE/MEDICAID CERTIFICATION A	AND TRANSMITTAL	ID: 55P9
PART I	- TO BE COMPLETED BY THE STAT	TE SURVEY AGENCY	Facility ID: 00598
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245366      2.STATE VENDOR OR MEDICAID NO.     (L2) 175040200	3. NAME AND ADDRESS OF FACILITY (L3) CHRIS JENSEN HEALTH & REHAB (L4) 2501 RICE LAKE ROAD (L5) DULUTH, MN	ILITATION CENTER  (L6) 55811	4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 11/01/2009 6. DATE OF SURVEY 08/23/2018 (L34)	7. PROVIDER/SUPPLIER CATEGORY  01 Hospital 05 HHA 09 ESRD  02 SNF/NF/Dual 06 PRTF 10 NF	02 (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other  8. Full Survey After Complaint
8. ACCREDITATION STATUS: (L10)  0 Unaccredited	03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 04 SNF 08 OPT/SP 12 RHC	15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:		
From (a):	A. In Compliance With	And/Or Approved Waivers Of The	e Following Requirements:
To (b):	Program Requirements Compliance Based On:	2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 170 (L18)	1. Acceptable POC	4. 7-Day RN (Rural SNF	<del>_</del>
13.Total Certified Beds 170 (L17)	X B. Not in Compliance with Program Requirements and/or Applied Waivers:	5. Life Safety Code  * Code: <b>B*</b>	9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SNF 170	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICABL	LE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY A	APPROVAL Date:
Susan Frericks, HFE - NE II	09/28/2018 (L19)	Joanne Simon, Enfor	· (L20

#### PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Participate		20. COMPLIANCE WITH CIVIL RIGHTS ACT:	<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>			
2. Facility is not Eligible	(L21)		_			
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION <b>08/01/1986</b>	BEGINNING DATE	ENDING DATE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY  05-Fail to Meet Health/Safety		
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCT A. Suspension of Admiss	ions: (L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
(1221)	B. Rescind Suspension Da	(L45)				
28. TERMINATION DATE:	29. INTERM	MEDIARY/CARRIER NO.	30. REMARKS			
	030	001				
	(L28)	(L31)				
31. RO RECEIPT OF CMS-1539	32. DETERM	INATION OF APPROVAL DATE				
	(L32)	(L33)	DETERMINATION APPROVAL			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 10, 2018

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

RE: Project Number S5366029

Dear Administrator:

On August 23, 2018, a standard 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 attached CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

#### **DEPARTMENT CONTACT**

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us

Phone: (218) 302-6151 Fax: (218) 723-2359

#### **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 2, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 2, 2018 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 form will be used as verification of compliance. 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

#### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

#### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

#### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 23, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date

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 February 23, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

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

PRINTED: 10/01/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245366	B. WING			08/	23/2018
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD ULLUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	On 8/20/18, to 8/2 completed at your pepartment of Heawas in compliance CFR Part 483, Sub Long Term Care Father as your allegation of Department's acceenrolled in ePOC, yat the bottom of the form. Your electron be used as verifical Upon receipt of an on-site revisit of your verification. Notice Requirement CFR(s): 483.15(c)(3) Notice Requirement CFR(s): 483.15(c)(3) Notice Requirement CFR(s): 483.15(c)(3) Notice Requirement (i) Notify the resident, the facility (i) Notify the resident representative of the language and man facility must send a representative of the Long-Term Care O (ii) Record the reas discharge in the resident of the language in	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with the en attained in accordance with the en attained in accordance with and the resident's fi the transfer or discharge and move in writing and in a ner they understand. The acops for the State mbudsman. Sons for the transfer or sident's medical record in sedical record i	FC	6623			10/2/18
I ABORATORY	and	aragraph (c)(2) of this section;  DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITLE		(X6) DATE

Electronically Signed 09/20/2018

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTE			E SURVEY MPLETED
		245366	B. WING			08/	/23/2018
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER				2501 RICE	DDRESS, CITY, STATE, ZIP CODE E LAKE ROAD , MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' EACH CORRECTIVE ACTION SHOI OSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 623	(iii) Include in the n paragraph (c)(5) of §483.15(c)(4) Timin (i) Except as specific)(8) of this section discharge required made by the facility resident is transfer (ii) Notice must be before transfer or (A) The safety of in be endangered und this section; (B) The health of in be endangered, un this section; (C) The resident's allow a more immedunder paragraph (c) (D) An immediate the required by the resunder paragraph (c) (E) A resident has a days.  §483.15(c)(5) Continuities a specified in must include the form (ii) The effective days.  §183.15(c)(5) Continuities a specified in must include the form (iii) The location to transferred or dischedity) A statement of including the name and telephone numereceives such required.	otice the items described in this section.  Ing of the notice.  fied in paragraphs (c)(4)(ii) and in, the notice of transfer or under this section must be at least 30 days before the red or discharged.  Individuals in the facility would der paragraph (c)(1)(i)(C) of individuals in the facility would der paragraph (c)(1)(i)(D) of individuals in the facility would der paragraph (c)(1)(i)(D) of individuals in the facility would der paragraph (c)(1)(i)(D) of individuals in the facility would der paragraph (c)(1)(i)(D) of individuals in the facility would der paragraph (c)(1)(i)(D) of individuals in the facility for 30 individuals in the facility would der paragraph (c)(3) of this section; ransfer or discharge; individuals in the facility would der paragraph (c)(3) of this section; ransfer or discharge; individuals in the facility would der paragraph (c)(3) of this section; ransfer or discharge; individuals in the facility would der paragraph (c)(3) of this section; ransfer or discharge; intensification in the facility would der paragraph (c)(3) of this section; ransfer or discharge; intensification in the facility would der paragraph (c)(3) of this section; in the facility would der paragraph (c)(3) of this section; in the facility would der paragraph (c)(3) of this section; in the facility would der paragraph (c)(3) of this section; in the facility would der paragraph (c)(3) of this section; in the facility would der paragraph (c)(3) of this section; in the facility would der paragraph (c)(3) of thi	F	23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245366	B. WING			08/2	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	hearing request; (v) The name, addrtelephone number of Long-Term Care Or (vi) For nursing facing and developmental disabilities, the mail telephone number of the protection and a developmental disact C of the Facility For nursing facility (vii) For nursing facility established under the for Mentally III Individual stabilished under the formation in effecting the transfer must update the reas practicable once becomes available.  §483.15(c)(8) Notice In the case of facility the administrator of written notification protection of the State Survey State Long-Term C of the facility, and the well as the plan for	ess (mailing and email) and of the Office of the State mbudsman; lity residents with intellectual disabilities or related ling and email address and of the agency responsible for advocacy of individuals with bilities established under Part ental Disabilities Assistance of 2000 (Pub. L. 106-402, C. 15001 et seq.); and illity residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder he Protection and Advocacy iduals Act.	F	523			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING _		08/	23/2018
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 2501 RICE LAKE ROAD DULUTH, MN 55811	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 623	483.70(I). This REQUIREMING. This REQUIREMING. Based on intervier facility failed to not initiated transfer for reviewed for hosp. Findings include:  R94's admission In 7/2/18, indicated of septicemia, parap R94's MDS also in the facility from the facility from the same day R94 hospital.  On 6/23/18, R94's was admitted to the note further indicated to the note further indicated at 11:30 101.7 F, and R94 midnight.  On 6/25/18, R94's was re-admitted to admitting diagnos intravenous (IV) and On 8/22/18, at 10 service SS-A verifited she	ENT is not met as evidenced and document review, the stify the ombudsman of a facility or 1 of 6 residents (R94) sitalization.  Minimum Data Set (MDS) dated diagnoses which included slegia and neurogenic bladder. Indicated R94 had admitted to e hospital on 6/23/28, and on 4 was discharged back to the sprogress note indicated R94 had a temperature of (F) and the nurse had called the spital who gave an order to the hospital if R94 spiked ure. The progress note further p.m. R94's temperature was was sent back to the hospital at a progress note indicated R94 of the facility on 6/25/18, with is of sepsis, and an order for	F 62	F623 □ Notice Requireme Transfer/Discharge:  "The Ombudsman has been the facility initiated transfer hospital that occurred on 6/2 Resident #94. The resident readmitted to Chris Jensen hospital stay on 6/25/18 and resident at Chris Jensen.  "The Ombudsman is notificated residents who have facility transfers to the hospital at 1. The format for communication hospital transfers has been revised.  "Nursing staff are completed discharge/transfer notice.  "Social service is responsicopy of the hospital dischard notices to the ombudsman.  "Monthly audits of all resident transferred out to the hospital that the ombudsman has been will be conducted by Social.	en notified of to the //23/18 for it was from the dremains a ed of other initiated least monthly. ating the reviewed and ing the hospital ble to send a rge/transfer ents ital to ensure een notified,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245366	B. WING _		08/	23/2018	
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD  DULUTH, MN 55811				
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F 623	On 8/22/18, at 2:20 ombudsman verifie R94's discharge to	p.m. the regional d she had not been notified of the hospital. ion of the ombudsman was	F 62	3			
F 640 SS=D	Encoding/Transmith CFR(s): 483.20(f)(2) \$483.20(f) Automate requirement-\$483.20(f)(1) Encode facility completes facility must encode each resident in the (i) Admission assess (ii) Annual assessmiti) Significant chart (iv) Quarterly review (v) A subset of item reentry, discharge, (vi) Background (fais no admission assessive) Background (fais no admission assessive) System information of the MI standard record lay and that passes states \$483.20(f)(3) Transmitted and the State \$483.20(f)(3) Transmitted and the State \$483.20(f)(3) Transmitted and states a facility and the state \$483.20(f)(3) Transmitted and states a facility and the state \$483.20(f)(3) Transmitted and states a facility and the state \$483.20(f)(3) Transmitted and states a facility and the states \$483.20(f)(3) Transmitted and states and the states \$483.20(f)(3) Transmitted and states and states and states and states and states and states are states and states and states are states and states and states are states and states are states and states and states are states are states and states are states are states are states and states are states are states are states and states are states are states are states are states and states are states a	ting Resident Assessments I)-(4)  ted data processing  ding data. Within 7 days after a resident's assessment, a te the following information for a facility: ssment. hent updates. hent updates. he in status assessments. w assessments. s upon a resident's transfer, and death. ce-sheet) information, if there sessment.  smitting data. Within 7 days bletes a resident's assessment, apable of transmitting to the nation for each resident DS in a format that conforms to routs and data dictionaries, andardized edits defined by	F 64			10/2/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08/:	23/2018	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 640	the CMS System. (i)Admission asses (ii) Annual assess (iii) Significant ch (iv) Significant cor (v) Significant cor assessment. (vi) Quarterly revi (vii) A subset of it reentry, discharge (viii) Background initial transmissio does not have an §483.20(f)(4) Dat transmit data in th for a State which by CMS, in the for approved by CMS This REQUIREM by: Based on intervict facility failed to er Minimum Data Se submitted for 1 or resident assessm Findings include: R1's Admission F diagnoses that in disease, and atria On 4/28/18, R1's died in the facility medical record la On 8/22/18, at 1:	including the following: essment. sment. ange in status assessment. rrection of prior full assessment. rection of prior quarterly  ew. ems upon a resident's transfer, e, and death. (face-sheet) information, for an of MDS data on resident that admission assessment.  a format. The facility must be format specified by CMS or, has an alternate RAI approved ormat specified by the State and State and State and State and State and State and several provides a Death in Facility bet (MDS) assessment was figure 2 residents (R1) reviewed for ment.  Record printed 8/23/18, indicated cluded dementia, chronic kidney	F 6	F640  Resident Assessn  The Death in Facility MDS was completed for R1 and submitted and accepted.  All residents MDS's have for timely transmission.  The system for timely con submission of MDS assess been reviewed and revised residents.  MDS coordinators have to re-educated regarding faci for timely completion of MI assessments to include the	S assessment has been reviewed impletion and sments has differ all been lity expectations DS		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245366	B. WING _		08/2	23/2018	
			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
facility, and the Debeen completed. Recompleted the discilist. RN-A also states acility MDS "fell the On 8/23/18, at 11:0 (DON) stated she to be completed time. The Resident Asset 10/17, directed, "A experience a signification discharged, and discharged assessments follow (comprehensive) arefers to when the dies while on a leafacility must compliance while on a leafacility must compliance accuracy of Asses CFR(s): 483.20(g)  §483.20(g) Accura The assessment in resident's status. This REQUIREME by:  Based on interview facility failed to accuracy of Asses CFR(s): 483.20(g) for eviewed for press	ath in Facility MDS had not the N-A stated she usually charge MDS using the census ed she thought the Death in nrough the cracks."  22 a.m. the director of nursing would expect all resident MDSs mely.  23 a.m. the director of nursing would expect all resident MDSs mely.  24 a.m. the director of nursing would expect all resident MDSs mely.  25 a.m. the director of nursing would expect all resident MDSs mely.  26 a.m. the director of nursing would expect all resident did not ficant change in status, was not don't have a Significant Comprehensive assessment, assessment scheduling would a cycle of three Quarterly wed by an Annual assessment. Death In Facility resident dies in the facility or ove of absence (LOA). The ete a Death in Facility tracking e assessment is not required." sments  27 and document is not required. The instance of the Minimum of the surately code the Minimum of the facility code the Minimum of the facility code the Minimum of the facility of the surately code the Minimum of the facility cod		" Audits of timely MDS assessment completion and submission/transm will be conducted by the MDS Direct audits weekly x 4 weeks, then one monthly x two months or as directe QAPI.  F641 □ Accuracy of Assessments: " Quarterly MDS dated 6/7/18 for R been corrected to include document of Stage 3 Pressure ulcer, and unstageable pressure ulcer with suspected deep tissue injury in	ission ctor two audit d by	10/2/18	
Findings include:			accordance with the wound			
	Continued From particular facility, and the Debeen completed. Recompleted the discompleted the discompleted the completed the facility MDS "fell the Correction to Prior (SCPA) completed the move through assessments follow (comprehensive) a refers to when the dies while on a lea facility must completed the move through assessments follow (comprehensive) a refers to when the dies while on a lea facility must completed then move through assessments follow (comprehensive) a refers to when the dies while on a lea facility must completed then move through assessments follow (comprehensive) a refers to when the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete to the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea facility must complete the dies while on a lea fac	ENSEN HEALTH & REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6 facility, and the Death in Facility MDS had not been completed. RN-A stated she usually completed the discharge MDS using the census list. RN-A also stated she thought the Death in Facility MDS "fell through the cracks."  On 8/23/18, at 11:02 a.m. the director of nursing (DON) stated she would expect all resident MDSs to be completed timely.  The Resident Assessment Instrument updated 10/17, directed, "Assuming the resident did not experience a significant change in status, was not discharged, and did not have a Significant Correction to Prior Comprehensive assessment (SCPA) completed, assessment scheduling would then move through a cycle of three Quarterly assessments followed by an Annual (comprehensive) assessment. Death In Facility refers to when the resident dies in the facility or dies while on a leave of absence (LOA). The facility must complete a Death in Facility tracking record. A Discharge assessment is not required." Accuracy of Assessments  CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments.  The assessment must accurately reflect the resident's status.  This REQUIREMENT is not met as evidenced by:  Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 4 residents (R31) reviewed for pressure ulcers, and 1 of 1 residents (R32) reviewed for insulin use.	ENSEN HEALTH & REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6 facility, and the Death in Facility MDS had not been completed. RN-A stated she usually completed the discharge MDS using the census list. RN-A also stated she thought the Death in Facility MDS "fell through the cracks."  On 8/23/18, at 11:02 a.m. the director of nursing (DON) stated she would expect all resident MDSs to be completed timely.  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		245366	B. WING _		08/2	23/2018
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2501 RICE LAKE ROAD DULUTH, MN 55811	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	R31's Admission indicated R31 had paraplegia (paraly T7-T10 (thoracic R31's quarterly M required total assiliving (ADLs) excedocumentation of an unstageable produced total produced tissue injury R31's Wound Door R31 had a suspect of the since 10/area on the coccy On 8/23/18, at 11: (LPN)-E and regist verified R31's MD R32's Admission indicated R32 had chronic kidney disdiabetes.  R32's electronic in (eMAR) dated Jurdiscontinued on 6 R32's significant of indicated R32 had past 7 days.  On 8/23/18, at 8: (LPN)-E indicated eMAR, and missed eMAR, and missed emands.	Record printed 8/23/18, diagnoses that included visis), unstable burst fracture of area of the spine), and epilepsy.  DS dated 6/7/18, indicated R31 istance with all activities of daily ept eating. The MDS lacked a Stage three pressure ulcer or ressure ulcer with suspected cumentation notes indicated eted deep tissue injury on the 12/17, and a Stage 3 pressure ex/sacrum since 12/29/17.  33 a.m. licensed practical nurse extered nurse (RN)-A both S was inaccurate.  Record printed 8/23/18, diagnoses that included eease, heart failure, and type 2 inedication administration record ne 2018, indicated insulin was	F 64	documentation notes.  " Significant change MDS da has been corrected to reflect discontinuation of insulin that 6/1/18.  " MDS for other residents has reviewed to ensure the accumentation on the MDS  " MDS coordinators have be re-educated regarding facility for accuracy with MDS to includer and medication use into the modern of the mode	et the at occurred on ave been aracy of coding een cy expectations clude pressure formation.  Its will be acy. These the MDS kly X4, then	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	L.	(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08/23/2018	
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E (X5) COMPLETION ATE DATE	
F 641 F 686 SS=D	be changed. Treatment/Svcs to CFR(s): 483.25(b)( §483.25(b) Skin Int §483.25(b)(1) Pres Based on the compresident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with processary treatments.	Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. orehensive assessment of a	F 641		10/2/18	
	new ulcers from de This REQUIREMEI by: Based on observat review, the facility for hygiene and glove wound care for 1 of during wound care, to ensure daily wou wound staging was Findings include: R15's quarterly Min 5/25/18, indicated of paraplegia, pressure pressure ulcer of the infection of the skin addition, the MDS is pressure ulcers (Full Parameters).	revent infection and prevent veloping.  NT is not met as evidenced and ion, interview, and document ailed to ensure proper hand use was maintained during a residents (R15) observed and addition, the facility failed and care was documented and accurate for R15's wounds.  Imagine Data Set (MDS) dated diagnoses that included are ulcer of the left buttock, and subcutaneous tissue. In andicated R15 had two Stage 4 all-thickness skin and tissue or directly palpable fascia,		F686 ☐ Pressure Ulcers:  "Resident 15 was discharged from Outling Jensen on 8/24/18 as previously plan.  "Other residents with pressure ulcershave been reviewed to ensure accuration with staging. These residents are receiving treatments as ordered by the physician. The treatments are done proper hand hygiene and glove use.  "Nurse managers have received re-education on appropriate staging of pressure ulcers.  "Licensed nurses have been re-educations for providing treatments as ordered by the providents are provided to the providents are providents as providents are providents are providents.	nned. s accy ne using of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING			08/:	23/2018	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		250	REET ADDRESS, CITY, STATE, ZIP CODE 11 RICE LAKE ROAD ILUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 686	muscle, tendon, li ulcer. Slough and Epibole [rolled ed tunneling often or location. If slough of tissue loss this Injury). The MDS pressure ulcer canot reject cares.  R15's care pland Stage 4 healing pwith Methicillin-reinfection (MRSA; resistant to many dressing changes monitor and docu appearance, and addition, the care facility policies/proprevention/treatmadminister treatmadminister treatm	gament, cartilage or bone in the /or eschar may be visible. ges], undermining and/or cur. Depth varies by anatomical or eschar obscures the extent is an Unstageable Pressure also indicated R15 received re, had intact cognition, and did ated 9/21/17, indicated R15 had ressure ulcers on admission, sistant Staphylococcus aureus a type of staph bacteria that is antibiotics) and received wound s. The care plan directed staff to ment the wound size, to stage the wounds. In plan directed staff to follow the otocols for the ent of skin breakdown and	F6		physician, and documenting any exceptions along with reason whattempts if the resident is refusir treatment.  "Licensed nurses have been reregarding facility expectations for hand hygiene and glove use to be maintained during wound care.  "Audits to monitor completion of ulcer treatments and audits of documentation as ordered by the physician will be completed by the Manager two audits weekly x 4, audits every other week x 2, and directed by the QAPI.  "Observational audits of proper hygiene and glove use during we will be conducted by Nurse Manaudits weekly x 4, then two audit other week x 2, and then as directed QAPI.	e he Nurse then two d then as hand ound care agers two ts every		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING			08/:	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER		25	FREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD ULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	bedside table. RN-E and set it to the right water. RN-B donne R15 had history of I beds. RN-B applied dressing around R1 RN-B picked up a basprayed the area to the area, and used skin and catheter to garbage. RN-B remperforming hand hy (which contained the out 4 centimeter (croperforming hand hy gloves, opened the gauze dressing around table and took a handful of gath plain water basin andful of gauze arbasin. RN-B reach saline (NS) solution opened the cap, and the gauze in the emboth wounds with the into the basin with gand obtained multiput to cleanse the wound gauze packet, grab and used them to did not change glow while doing the wounders. RN-B reach saline (RN-B) reach saline the mound gauze packet, grab and used them to did not change glow while doing the wounders. RN-B reach	ge 10  ter, and set both basins on the 3 took an empty wash basin at of the wash basin with plain d a clean gown. RN-B stated MRSA infection in the wound I gloves, and removed a soiled 5's suprapubic stoma site. Tottle of wound cleanser, and vice. RN-B used gauze to wipe an alcohol wipe to clean the abe, and tossed the wipe in the loved her gloves and without rgiene, reached into the closet e wound supplies) and took m) by 4 cm gauze. Without rgiene, RN-B donned clean gauze wrap, applied the clean und R15's stoma site, and 3 removed her soiled gloves, to the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned a clean pair of the left side, and without rgiene, donned clean pair of the left side, and without rgiene, donned clean pair of the left side, and without rgiene, donned clean pair of the left side, and without rgiene, donned clean pair of the left side, and without rgiene, donned clean pair of the clean pair of the left side, and without rgiene, donned clean pair of the left side, and without rgiene, reached into the clean pair of the left side, and without rgiene, reached into the clean pair of the left side, and the left side rgiene, reached into the clean pair of the left side rgiene, reached into the clean pair of the rgiene, reached into the clean pair of the rgiene, reached	F6	586			

CLIVILI	13 I ON MEDICANE	- A MEDICAID SERVICES				NIVID INC.	. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY IPLETED
		245366	B. WING			08/	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & R	EHABILITATION CENTER		250	REET ADDRESS, CITY, STATE, ZIP CODE  1 RICE LAKE ROAD  LUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	wound. Before covidressing, the surver RN-B to remove the used them to clear the soiled gloves, a Without performing applying clean glowintervened, and as before donning cle pack both pressure moistened with No ABD dressings on taped the dressing her gown and glowing garbage, and without applied clean of glopieces of gauze with cleansed an open and patted the area basins with soapy them to the bathroot the toilet. RN-B rinse	these to start packing the ering the wounds with a eyor intervened and asked e soiled gloves as she had a the wounds. RN-B removed and reached for clean gloves. It is gloves. Again the surveyor ked RN-B to wash her hands an gloves. RN-B proceeded to e ulcers with multiple gauzes rmal Saline solution, applied top of the pressure ulcers, and is to the skin. RN-B removed es, tossed them in the out performing hand hygiene, oves. RN-B moistened two th the wound cleanser, area on R15's left great toe, a dry. RN-B picked up the water and plain water, brought om and dumped the water in sed the basins in the sink, digloves and performed hand	F6	886			
	documentation, inc 8/14/18: Evening s A note indicated R <sup>2</sup> 8/15/18: Day shift, 8/16/18: Day shift, 8/21/18: Evening s A progress note inc the nurse approach	hift, no wound care completed.					
	On 8/23/18, at 9:08	3 a.m. licensed practical nurse					

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING	i		08/:	23/2018	
	PROVIDER OR SUPPLIER ENSEN HEALTH & RI	EHABILITATION CENTER		25	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD ULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	8/14/18. LPN-B ver documented as cor and 8/16/18. LPN-E expected to write a completed. LPN-B appointment at 9:00 however, LPN-B wreturned to the faci documentation that or attempted to be appointment. LPN-appointment on 8/1 documentation to enot completed. LPN nurses to reapproarefused or not completed. LPN-B also verified nurses should have nurse to approach ordered. LPN-B statem LPN-B also verified nurses should have nurse to approach ordered. LPN-B statem LPN-B further statem that the separate gloves for when cleaning ther soiled gloves, wash of gloves before parapplying the clean of the completed wound control procedures nurses were to documented to make the completed wound control procedures nurses were to documented to write a completed wound control procedures nurses were to documented to write a completed wound control procedures nurses were to documented to write a completed wound control procedures nurses were to documented to write a completed wound control procedures nurses were to documented to write a completed wound control procedures nurses were to documented to write a completed wound control procedures nurses were to documented to write a complete to	I5 was not out of the facility on iffied wound care had not been impleted on 8/14/18, 8/15/18, 8 stated the nurses were note to explain why it was not stated on 8/15/18, R15 had an 0 a.m. with pick up 8:00 a.m. as not sure when R15 had lity, and there was no at wound care had been offered completed after the B stated R15 had no medical 6/18, and there was no explain why wound cares were N-B stated he would expect the ch R15 if wound care was pleted, and all the nurses were plets in the medical record. If on 8/21/18, and 8/22/18, are communicated to the next R15 to do the wound care as ated R15 had a history of the ulcers. If an an an an an an and event infections to the wounds. If and was supposed to use of each of the pressure ulcers in, and was to remove the in hands, and apply a clean pair tacking the wounds and	F	686				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245366	B. WING _		08/	23/2018
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 686	wound care  On 8/23/18, at 10:0 wound care was no procedure. RN-B st procedure, she wo washed her hands, wound care. RN-B sand this was how si complete the wound not washed her har required on multiple wound care. RN-B for developing infectompleted the wound care. RN-B for developing infectompleted the wound the residual response to care are the facility Hand W directed staff to some water thoroughly for to wash fingers and that were contamination; staff that were contamination; staff were to wash the word would be supported to wash the same contamination; staff that were to wash the word would be supported to wash the same contamination; staff that were to wash the word wash the same contamination; staff were to wash the word wash the same contamination; staff were to wash the word wash the same care wash to same care wash the same c	6 a.m. RN-B stated R15's t intended to be a sterile ated if it was a sterile uld have removed her gloves, and proceeded with the stated this was not the case, he understood she was to d care. RN-B verified she had had and removed gloves as a times when completing acknowledged R15 was at risk stions, and she stated she had had care as taught.  The Injury/Skin Integrity/Wound revised 11/16, directed the daily and/or routinely ents skin condition, the had treatment to the skin.  Tashing policy dated 4/1/08, ub their hands with soap and r 20 seconds, and staff were	F 68	36		
	CFR(s): 483.25(d)(	, , ,	F 68	39		10/2/18
	§483.25(d) Acciden	ts.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING			08/2	23/2018
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		25	REET ADDRESS, CITY, STATE, ZIP CODE  501 RICE LAKE ROAD  ULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	The facility must e §483.25(d)(1) The as free of accident stree of accident supervision and a accidents. This REQUIREMED by: Based on observing review, the facility interventions to review, the facility interventions to reviewed for accidents (R95, R to conduct ongoin of falls to determining falls to determining for falls for accident for ac	ensure that - e resident environment remains it hazards as is possible; and the resident receives adequate ssistance devices to prevent ENT is not met as evidenced ation, interview, and document failed to implement identified duce the risk for falls for 2 of 6 13). In addition, the facility failed g comprehensive assessment the causal factors to reduce the of 6 residents (R95, R147, R26) Idents.  In mum Data Set (MDS) dated diagnoses that included son's disease and diabetes. The ed R95 was severely cognitively diextensive assistance for all fiving (ADLs) and was frequently well and bladder. R95's care plan or falls related to confusion and of and indicated R95 was	F6	689	F689 □ Accidents:  "Resident 95 no longer resides at O Jensen.  "Identified fall intervention risks have been reviewed, revised if indicated a implemented for R13.  "A comprehensive assessment of fadetermine causal factors to reduce risk of falls has been completed and ongoing for R147 and R26.  "Other residents with falls are asset to determine causal factors to reduce of falls. Resident centered interventare determined and implemented wongoing review if falls continue to ou "Falls are reviewed by the IDT for recommendations. Residents with multiple falls include a review of the history, multiple fall causal factors, of interventions and resident centered approach to falls.  "Nursing staff have been re-educative regarding facility expectations for fa prevention and response.  "Audits of care plan interventions at observation of implementation will be completed by Nurse Manager two a weekly x4, then two audits every of week x2, then as directed by QAPI.	re and alls to the d is ssed ce risk tions ith ccur. fall current ed ll nd re udits	

OLIVILI	TO I OIT WILDIOAIT	- WINEDICAID SERVICES			OMD IN	O. 0930 <del>-</del> 0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245366	B. WING		0	8/23/2018		
	PROVIDER OR SUPPLIER  ENSEN HEALTH & R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZII  2501 RICE LAKE ROAD  DULUTH, MN 55811	PCODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 689	fading yellow bruis propelling himself member pushed h where a television was propelling him a.m. R95 attempte elevator door, regiand told R95 he neasked RN-B who seed the seed anything to anything to any a soffered anything to anything to any a soffered anything to anything to any a soffered anything to any the seed anything the seed anything the seed anything the another residents were sittle eyes closed, a four wheel chair with he another residents during the another residents during the seed another the elevator door. In allow him to lest button again, and a back to his table in away. R95 propelled headed back to the elevator door oper but his wheel chair preventing him from elevator door oper attempted to get in back to the table in ba	e on his forehead. R95 started down the hallway. A staff im back into the dining room, was on to a talk show. R95 self in the dining room. At 7:46 d to exit the unit via an open stered nurse (RN)-B intervened seeded his hearing aids. R95 she was and called her a name. Corted back to a table in the taff member, but was not eat or drink. A linen napkin se were on the table. R95 se box of tissues onto the table. If himself away from the dining time, a radio was playing a d three other men were sitting one was talking. Three othering in the dining room with their th resident was sitting in a ser hands covering her face, and at alone at a table with her ent of her. There was no engage R95 or the other e observation. At 8:18 a.m. attempt to exit the unit through Staff again intervened, and did ave. R95 pushed the elevator a staff member brought him the dining room and walked ed away from the table and elevator. At 8:25 a.m. the led, and R95 attempted to exit was stuck on the wall med again, and R95 again and R95 ag	F 6	89				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
		245366	B. WING		0	8/23/2018
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 2501 RICE LAKE ROAD DULUTH, MN 55811	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	it to R95. R95 thresecond time and a wheel chair to pick the floor, R95 fell LPN-C responded "You did that on pistated to another on purpose." LPN again asked him was remained lyin R95, "You threw y do that?" At this time with five staff mendisplayed signs of staff and squeeze with the other han certified nurse praaked R95 was lying, an stated R95 put hir had been wild all in to punch staff. Du no attempts by statiolleting or any stated R95 was stooleting or any stated R95 was stood up and slid R95 had numerous issues. An interdisticated R95 was stood up and slid R95 had numerous issues. An interdisticated, and R95 nurses station who	page 16 e picked up the napkin and gave ew the napkin under the table a attempted to stand up out of the k it up. While trying to kneel on onto his right side on the floor. It to the fall and stated to R95, urpose didn't you?" LPN -C then staff member, "He so did that -C then turned to R95 and why he put himself on the floor. It is gon the floor. LPN-C stated to ourself on the floor, why did you me, R95 remained on the floor onbers standing over him. R95 agitation. R95 attempted to hit d LPN-C's hand, pointed at her d and stated, "It was you." The actitioner walked over to where d asked what happened. LPN-C mself on the floor, and stated he night, throwing things and trying ring the observation there were aff to offer R95 fluids, food, aff or activity engagement.  It documents identified the ont Report dated 7/30/18, sholding onto a fire door bar, to the floor. The report indicated is falls, and had impulse control sciplinary team (IDT) Root ted 8/1/18, indicated a walking with impulse control was was to be moved closer to the en a room became available.	F	589		

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245366	B. WING			08/	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & R	EHABILITATION CENTER		250	REET ADDRESS, CITY, STATE, ZIP CODE 11 RICE LAKE ROAD ILUTH, MN 55811	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	indicated R95 was with his arm and el pressure pad alarm extensive fall historijudgement. An IDT 8/1/18, indicated coif it helps.  A Resident Incident indicated R95 was on his buttocks and against the bed. The was placed, and in manipulating alarmindicated R95's preand replaced with a A Resident Incident indicated R95 was wheelchair, and an assist, causing R98 Review dated 8/10 therapy to screen faneed for new antital A progress note days witnessed put his wheel chair.  A Falls Risk Post - 8/14/18, indicated and sustained a fal dated 8/14/18, indicated and sustained a fal dated 8/14/18, indicated Indicated 8/14/18, indicated	found sitting on his fall mat bow still on the bed on n. The report indicated an ry, impulse control, and poor Root Cause Review dated onsider walking program to see t Report dated 8/3/18, found on the floor mat sitting d leaning on his left side he report indicated a tabs alarm dicated R95 had a history of is. An IDT Root Cause Review essure alarm was removed,	F 6	89			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
		245366	B. WING			08/	23/2018
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		250	REET ADDRESS, CITY, STATE, ZIP CODE  1 RICE LAKE ROAD  LUTH, MN 55811	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	numerous times to When staff attem hitting, kicking, and hitting, kicking, and A progress note of was aggressive of himself on the floor safely by staff.  A progress note of witnessed R95 stallay himself down brief was noted to sustained an abraic (cm) x 1.5 centimerolling himself and A Resident Incide indicated R95 fell in his wheelchair correlating progrem R95 was propelling room, and put him attention."  On 8/23/18, at 9:4 stated R95 would stated staff keep because he will "put the floor. NA-B stated R95 could stated if staff asked sometimes tell the by the nurse's stakept him there, and On 8/23/18, at 10	to throw himself out of bed. pted to reposition R95, he was and punching.  Ilated 8/21/18, indicated R95 In night shift, and tried to put or. R95 was lowered to the floor  Ilated 8/22/18, indicated staff and up from his wheel chair and on the floor. R15's incontinence to be wet at the time. R95 Insight shift, and tried to put or.  Ilated 8/22/18, indicated staff and up from his wheel chair and on the floor. R15's incontinence to be wet at the time. R95 Insight shift shi	F 6	889			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245366	B. WING			08/	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER		25	REET ADDRESS, CITY, STATE, ZIP CODE 01 RICE LAKE ROAD JLUTH, MN 55811	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	himself out of his clared roll out of bed. LPN in jail at the facility, was there to stay. Landbody was paying On 8/23/18, at 10:3 fall occurs, the nursterm intervention, the information and reversely past. LPN-B stated meeting, and the teworking on other unand initiated or chastated R95 had a sthere were numero. During an interview family member (FN has laid in bed for hup. FM-A stated fall pay attention.  During a subseque p.m. R95's falls we LPN-B stated their continue with the continue wit	hair. LPN-D stated R95 would l-D stated R95 thought he was and did not understand he l-PN-D stated R95 would say	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING			08/	23/2018
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER				250	EET ADDRESS, CITY, STATE, ZIP CODE  1 RICE LAKE ROAD  LUTH, MN 55811	, ,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Seroquel, LPN-B sinot been adjusted discontinued when R13's annual MDS diagnoses that incl. The MDS further id cognitively impaired assistance with AD incontinent of bower R13's care plan daralls related to demincontinence, and the care plan direct in bed, keep the bear edirect when agital identified the use of get up on overnighmattress at bed sidentify a frequency On 8/22/18, at 7:51 sitting in her wheeled brakes on her wheeled brakes	dated the Seroquel order had until 8/22/18, and was R95 admitted to hospice.  dated 5/24/18, indicated uded dementia, and diabetes. Jentified R13 was severely d, required extensive Ls, and was frequently el and bladder.  ted 5/24/18, identified a risk for rentia, bowel and bladder behaviors with impulsiveness. Sted at a seated height, and lated. The care plan also f a scoop mattress, offers to a last rounds, and anti-skid le. Further, the care plan esist with toileting, but did not y.  I a.m. R13 was observed chair. R13 had auto locking elchair, and was propelling on the halls on the unit.  I a.m. R13 was observed chair. R13 had auto locking elchair, and was propelling on the halls on the unit.  I a.m. R13 was observed chair. R13 had auto locking elchair, and was propelling on the halls on the unit.  I a.m. R13 was observed chair. R13 had auto locking elchair, and was propelling on the halls on the unit.  I a.m. R13 was observed chair. R13 had auto locking elchair, and was propelling on the halls on the unit.  Tocuments identified the m. The report indicated a DT Root Cause Review dated etaff were to offer to get R13	F6	89			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245366	B. WING _		80	/23/2018		
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2501 RICE LAKE ROAD DULUTH, MN 55811				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 689	Continued From paindicated R13 was	age 21 found sitting up next to her	F 68	39				
	bed. An IDT Root	Cause Review dated 6/6/18, e to offer to get R13 up at 7:00						
	indicated R13 was on the floor. An ID 7/2/18, indicated s	nt Report dated 6/30/18, found sitting against her bed T Root Cause Review dated taff were to check on R13 at ds, and offer to get her up.						
	indicated R13 was slid off as staff app A IDT Root Cause	nt Report dated 8/8/18, found sitting on her bed and broached, landing on the floor. Review dated 8/8/18, indicated ess was placed on the floor next						
	indicated R13 was supporting herself	nt Report dated 8/11/18, found sitting next to her bed with one arm. An IDT Root ed 8/13/18, indicated a six day be implemented.						
	study was initiated pattern for R13 ho completed by staff had been no follow	7 p.m. LPN-B stated a sleep on 8/13/18, to determine a wever, the sleep study was not LPN-B further stated there y-up with the night shift to yas getting up on the overnight						
	(DON) stated the I discuss falls. The I the time of day the resident was hung use the bathroom.	6 p.m. the director of nursing DT met every Monday to DON stated the IDT discussed falls occurred, whether the ry, thirsty or if they needed to The DON stated the team also eness of the interventions, and						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		245366	B. WING _		80	3/23/2018
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	nurse manager wa on fall interventions R147's Admission identified R147's d difficulty in walking R147's admission R147 had severe opsychoactive medi incontinent of urine with toileting. The I had falls with injury since admission. R147's ADLs care R147's ADLs care R147 required exterior with a walker for an on the care plan darefused assistance walker. A 2/13/18, R147 was indepentiollet upon rising, band as needed. Statollet R147 every for hand written note offer rest period wi 8/6/18, hand writtel lay down after luncindicated no ambut 1-2, stand pivot we R147's Safety/Falls directed use of a waccess, check for etc., ensure enviror review facility protocall light to request locked placement. indicated nonskid fadded. On 2/7/18,	s responsible for following up	F 68	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION		E SURVEY PLETED
		245366	B. WING			08/:	23/2018
	PROVIDER OR SUPPLIER  ENSEN HEALTH & RI	EHABILITATION CENTER		2501	EET ADDRESS, CITY, STATE, ZIP CODE I RICE LAKE ROAD LUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	resident frequently periods. On 3/6/18, to redirect to sit do allows, offer rest per hand written note in wedge between restolerated. On 8/8/18 indicated a pad ala Review of the R147 the following falls: On 1/26/18, at 12:4 hands and knees of her room. Had bee at 11:00 p.m. State areas noted, no sw Very pleasant and conversation per note at 12:7/18, at 6:13 fall at 5:40 p.m. in hunsteady and agita assist in any way. Find the following again out of resident fell allow any assistance Resident immediate began walking again out of resident's had from area by staff. notify of fall and ag On 1/29/18, at 3:33 witnessed fall on a p.m., she was walk her back landing in wheelchair. She the done, was having a up off the floor with	noncompliant with offered rest a hand written note indicated which in dining room as resident with dining room as resident with sweets. On 8/6/18, andicated place abduction sident's legs at meal times as 8, a hand written note rm to wheelchair.  The progress notes indicated  6 a.m. Found crawling on an the floor in the doorway to an toileted and helped into bed and helped into bed and her knee gave out. No reduction or obvious deformities. Cooperative. Confused ormal but was smiling.  Alked to bed, denied having to but then said she had to go.  In p.m. Resident had witnessed hallway. Resident walking ted. Would not allow staff to desident angry and carrying a conto left side and would not be or vitals to be taken.  Bely stood up on own and and in; did not hit head. Knife fell and and was quickly removed writer spoke with husband to	F6	689			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION		` '	E SURVEY PLETED
		245366	B. WING			08/:	23/2018
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2501 RICE LAKE ROAD DULUTH, MN 55811	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD E	BE	(X5) COMPLETION DATE
F 689	been sitting there. was saying aggres other residents. No Tylenol at approximate to monitor for injury time.  On 2/25/18, at 11:5 on buttocks on the the back against the tray table was local left of the resident. The resident stated table and I sat downwitnessed, neur and remained at recomplain of a slight area, no injury/rediwent away within 5 took my medication moves all extremiting guarding. No injuring nonskid footwear of 0920, voided and we resident was seen room conversing whas history of falls Placed another charesident was stand chairs to stand againg print with resident was stand chairs to stand againg print with resident was stand againg print with resident was stand chairs to stand againg print with resident was stand againg print with a down picture of a chair, put that row and so it of is pacing the hallword and is in a lit is also noted that Risperidone 0.25 medical support of the standard so it o	the dining hall chairs and has As she was sitting there she sive things towards staff, and complaint of pain, did have nately 1:40 p.m. Will continue y, but no apparent injury at this 50 a.m. Resident found sitting floor in the dining room with ne wall in between two chairs, a ted in front of the chair to the When asked what happened, , "I tried to sit down on the When asked what happened, , "I tried to sit down on the sident's baseline. Resident did at discomfort in left forearm ness/bruising noted. The pain is minutes, resident stating, "I has this morning." Resident its without any pain or les noted. Care plan followed, on, resident last toileted at was continent. Just prior to fall standing against wall in dining with other residents. Resident very similar to this in nature. It is in the row of chairs where ling so no room in between ainst wall, also made sign in ident's first name and, "Sit lineard pointing arrow and a positioned right above a chair in the can also be seen when resident and agreement that it is worth a try. It resident started on milligrams (mg) mg twice a day Risperidone was increased to	F6	589			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION DING	· ,	TE SURVEY MPLETED
		245366	B. WING	i	08	/23/2018
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 2501 RICE LAKE ROAD DULUTH, MN 55811	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 689	0.5 mg twice a da 2/5/18, 2/10/18, a resident had falls and was also treat it is also noted the resident had had outbursts, decreat experience a stability of the stability of t	ay and resident had falls on and today. It is also noted that prior to the start of Risperidone ated for a urinary tract infection. At since the start of Risperidone, a marked decrease in violent use in behaviors, starting to bilization of mood. This was in it in husband, none as causation, and as data collection to give to still and PCP [primary care and neurological double to the play balloon as, using all extremities without to some and the wall and falling to the floor. Observed and falling to the floor. Observed and falling to the floor. Observed and the hallway, but was a large noise ancident. Resident was found side in the hallway, but was a flower than the wall and the hallway and so the floor. Observed and the hallway are noise ancident. Resident was found side in the hallway, but was a large noise ancident. Resident was found the hallway and the hallway and the hallway are all mild weakness in extremities in the hallway. No other all mild weakness in extremities in the sisted up off the floor two down to the dining room. Ice to resident head for 20 minutes. Resident able to follow the a good dinner. DON [director egistered nurse] manager, and family notified of incident. No	F	589		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		` '	E SURVEY PLETED
		245366	B. WING			08/:	23/2018
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 2501 RICE LAKE ROAD DULUTH, MN 55811	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 689	symptoms of conclater observed to a socializing with star appropriately. On 4/22/18, at 2:2 in dining area and from another resident. Resident witnessed fall. Wr manager on call a to incident. Faxed rounding book. Note to observe. On 4/2 antipsychotic med see if it was causi On 5/8/18, 11:00 a Assessment indicated that occurred in nonskid footwear, conditions: psychicorthopedic/joint/arpsychotropic, antiunsteady at times incontinence of blue Dementia. Was proportionally on 5/8/18, at 11:0 indicated R147 was resident pushed resident push	ontinue to monitor for signs and cussion or injury. Resident was walking around the unit aff and other resident  O p.m. Patient was ambulating fell backwards due to a push dent. No apparent injury and didn't hit her head, this was a iter spoke to Chris Jensen and patient's husband in regards incident report left in Doctors euro status intact-will continue 27/18, haloperidol (Haldol, an ication) was discontinued to ing/contributing to falls.  a.m. Falls Risk Post Fall ated the following. R147 had a in end lounge room. Wearing underlying diseases or atric or cognitive conditions, thritis, seizures. Takes eseizures. Functional status: receiving rehab, occasional adder, self-toilets at times. Ushed by another resident.  O a.m. an IDT Root Cause note as in lounge, and another esident to floor, and she landed lent did not hit head, and no cident. Fall was witnessed by a factors: repeated falls, muscle intation unspecified. IDT ause of fall to be pushed by p.m. Kitchen staff found loor. Staff intervention: o checks, moved all laint of pain directly above left.	F 6	89			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245366	B. WING	i		08/:	23/2018
	PROVIDER OR SUPPLIER  ENSEN HEALTH & RI	EHABILITATION CENTER		250	REET ADDRESS, CITY, STATE, ZIP CODE 11 RICE LAKE ROAD ILUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	breast and below let Call to family/MD w On 6/7/18, at 5:15. Assessment: Fall in unwitnessed fall, por Current intervention encourage resident cognitive issues: us and anti-seizure maleans to right when Root Cause 6/8/18 Resident found on factors: weakness/determined root caunit. New/Different place related to roof fluids and snacks. psychiatrist notes in neurocognitive disciplinary at age of 5, plikely Alzheimer's. In and agitation along and thoughts. Milk resolved, controlled disorder with deluscausing agitation a with current therapt psychotropic, monimovement issues of for sedation and famedication current reevaluate medication at 12:30 a.m. in bar buttocks trying to get a service of the service of	eft breast. No injuries noted. with notification. p.m. a Falls Risk Post Fall indicated R147 had an rior to ambulating in hall. Ins: safety monitoring, it to rest. Psychiatric or se of psychotropic medication edication. Functional status: tired and ambulating. IDT, for fall on 6/7/18, at 5:15 p.m. floor in dining room. Causative unsteady gait, dementia. IDT use of fall to be: ambulating on period interventions now in ot cause: offer rest period with On 6/15/18, R147's indicated, "Major orders due to known tion, history of traumatic brain progressive cognitive decline Now with physical aggression with delusional statements [sic] increase in agitation now d. Anxiety disorder, psychotic ions, and significant paranoia and aggression. 'Well controlled y.' High risk medication use on toring weight, screening for on a monthly basis. Monitoring lls benefits of anti-psychotic ly out weight risks. Will tions on a monthly basis and	F	689			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245366	B. WING			08/:	23/2018
	PROVIDER OR SUPPLIER  ENSEN HEALTH & RE	EHABILITATION CENTER		250	EET ADDRESS, CITY, STATE, ZIP CODE  1 RICE LAKE ROAD  LUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	unable to tell nurse prior to event due to call notified regardino acute pain and heuro's and vital sinotify family and makesessment: for the indicated R147 was bathroom. Injury: recurrently being use position, frequent vocauses: psychiatric medications Psychefunctional status: missues. Resident fositting on butt, trying six day bowel and kon 6/28/18, at 12:30 a. bathroom door way up. No apparent injusting disorientation, repecause to be: wantin New/different intervot cause: six day On 7/26/18, at 10:4 nurses station on 7 indicated pain in rigstraighten right legunit coordinator] wapacket). Resident vocadmitted for further physician notified on 7/26/18, a Falls indicated the follow while ambulating painterventions: nons	what she was trying to do poor cognition. Doctor on ing injury to head. Resident in helped back into bed with gns started. Day nurse to anager. A Falls Risk Post Fall e fall 6/28/18, at 12:30 a.m. in the bathroom, trying to use ed mark. Fall interventions d. Gripper socks, bed low ital signs, toilet. Underlying or cognitive, seizures/tremors, otropic, anti-seizures, nobility issues, cognitive und in bathroom doorway g to get up. No apparent injury, loadder study. For the fall on in indicated resident found in sitting on butt, trying to get ury. Unsteady gait, ated falls. IDT determined root ing to use the toilet. The entions now in place related to bowel and bladder study. In the pand was unable to without pain. Unit HUC [health as witness to fall (See fall was sent to St. Luke's for evaluation and was treatment. Family and	F6	689			

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245366	B. WING	;		08/2	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER		250	REET ADDRESS, CITY, STATE, ZIP CODE 01 RICE LAKE ROAD JLUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	cognitive conditions Medications psychology Functional status: a continent of bladde Cognitive issues, not be about five following: (fall 7 fall: resident attem backwards by nurse Review of causative history of falls IDT of be: ambulating on the New/different intervals Root Cause: send to R147 was hospitalized this fracture sure 7/26/18. R147 return On 8/2/18, at 11:10 unwitnessed fall in 8/2/18, at 3:30 p.m. transfer self to bed about five minutes appeared intact and right hip joint with no impingement. Neur due to fall being un and attempted to not message as there in pass to next shift. A Assessment dated 15:30-fall occurred transfer self to bed intervention Low bed intervention Low bed intervention.	s or conditions. Psychiatric or s, ortho/joint/arthritis/seizures. otropic, anti-seizures. Insteady at times, mostly r. Self-toilets at times. ot able to communicate needs. ell backwards on right side. Room for evaluation. On toot Cause Review indicated 1/26/18 at 3:40 p.m.) Prior to pted to catch balance and fell elles station. Fall with injury. The factors: unsteady gait and determined root cause of fall to the unit and knee gave out. The entions now in place related to the Emergency Room. The entions in the facility on 7/31/18. The entions in the facility on the entiol to the facility on 7/31/18. The entions in the entiol to the facility on 7/31/18. The entions in the entions of the entiol to the facility on 7/31/18. The entions in the entions of the en	F	689			

medications, anti-seizures, antihistamines.

OLIVILI	TO TOTA MEDIONIA	A MEDICAID SERVICES				NVID INC.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY IPLETED
		245366	B. WING	i		08/	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER		25	REET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD ULUTH, MN 55811	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	safety awareness, needs, change in p Resident attempting safety checks and of the IDT Root Cause 15:30 p.m.) indicate unwitnessed fall in of causative factors weakness. IDT dete be: Self transfer to interventions now in offer to lay down af The Fall Log, recon- indicated R147 had 1/22/18, in the dining the intervention was day bowel and blad 1/25/18, in bedroom the intervention was screen, x-ray right of 1/27/18, in hallway intervention was me management. 1/29/18, in hallway intervention was no assessment. 2/5/18, in dining root the intervention was in bed after lunch. 2/10/18, in dining root the intervention was in bed after lunch. 2/10/18, in dining root the intervention was in bed after lunch. 2/10/18, in dining root the intervention was to room. 2/25/18, in dining root intervention was to room. 2/25/18, in dining root a.m. intervention was to room.	unsteady gait, wheelchair, No not able to communicate ain level (recent fractured hip). It is good to self-transfer. 15 minute continue low bed. On 8/6/18, It is exercised to fall resident had bedroom next to bed. Review is: unsteady gait/muscle ermined root cause of fall to her bed. New/different in place related to Root Cause: ter lunch. It is falls: It is groom with no injury at 6 p.m. is 3 sleep observation and 3 der tracking. In with no injury at 11:30 p.m. is PT [physical therapy] to	Fé	689			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245366	B. WING			08/2	23/2018
	PROVIDER OR SUPPLIER  ENSEN HEALTH & RI	EHABILITATION CENTER		25	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD ULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	bump on right side intervention placed minutes due to agg 4/6/18, in dining rot 2:10 p.m. the intervention wa other residents. 5/8/18 in the lounge the intervention wa resident's space. 5/24/18, in another no injury at 10:00. day bowel and blace 6/7/18 in the dining p.m. the intervention fluids and snacks. 7/26/18, by the nurst of the emergency in the intervention was of 8/7/18, in bedroom intervention was of 8/7/18, in dining root the intervention was wheelchair. 8/9/18, in dining root the intervention was get stronger to use R147 had between information in the content of the fall with hip frace falls after returning lacked patient cent interventions for ear R26's Admission R indicated R26 had repeated falls and of the falls and content of the fall with hip frace falls after returning lacked patient cent interventions for ear R26's Admission R indicated R26 had repeated falls and content of the fall with hip frace falls after returning lacked patient cent interventions for ear R26's Admission R indicated R26 had repeated falls and content of the fall with hip frace falls after returning lacked patient cent interventions for ear R26's Admission R indicated R26 had repeated falls and content of the fall with hip frace falls and content of the fall with hip frace falls after returning lacked patient cent interventions for ear R26's Admission R indicated R26 had repeated falls and content of the fall with hip frace falls and content of the fall with hip frace falls and content of the fall with hip frace falls and content of the fall with hip frace falls and content of the fall with hip frace falls and content of the fall with hip frace falls and content of the fall with hip frace falls and content of the fall with hip frace falls and content of the fall with hip frace falls and content of the fall with hip frace falls and content of the fall with hip falls and	of head at 4:40 p.m. on 1:1 for short period, 30 pression. om/lounge with no injury at vention was medical workup. om with no injury at 2:20 p.m. is to attempt to redirect from e with no injury at 11:00 a.m. is redirect resident from other resident's room/bathroom with The intervention was to do 3 lder study. room with no injury at 5:15 on was to offer rest periods with se's station at 3:40 p.m. sent oom, resulted in a hip fracture. 17/18, returned to facility on with no injury at 3:30 p.m. fer to lay down after lunch. om with no injury at 6:15 p.m. is chair pad alarm on om with no injury at 8:30 p.m. se continue with therapy to help walker. 11 and 15 falls (conflicting chart and on the fall log) prior to octure on 7/26/18; and 1 to 3 to the facility. The facility ered interventions, or different ich fall. ecord printed on 8/23/18, diagnoses that included	F	689			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245366	B. WING	;		08/:	23/2018
	PROVIDER OR SUPPLIER  ENSEN HEALTH & R	EHABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 689	had cognitive loss communication, an R26's care plan rev R26 wandered, rur others belongings, The care plan indic become angry with falls related to histomedication, Alzheir cares. On 6/6/18, scoop mattress, gr seated heights, nor checks while in bethen having increas indicated R26 ambindicate that R26 wor leave walker bel On 8/20/18, at 7:55 walking away from walker, RN-H notic length of the dining least 15 feet. On 8/21/18, at 9:45 walking through the walker. A houseker and NA-H were in notice. A nurse pas notice. On 8/21/18, at 10:0 walking without wanursing station, and did not notice she clooked at R26 and On 8/21/18, at 10:0 walking without her twice, a nurse in th staff for care confernal was in the dining the staff for care care care care care care care car	and dementia, impaired and had a decline in continence vised 12/31/16, indicated the immaged, and shopped through and believed they were hers. Eated R26 would yell and redirection, was at risk for ory of falls, impaired mobility, mer's and need for assist with a hand written note indicated ipper socks at bedtime, bed at in-skid footwear. Frequent d, attempt to redirect resident sed behaviors. The care plan ulated with walker, but did not yould walk away from walker,	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING		0	8/23/2018
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STAT 2501 RICE LAKE ROAD DULUTH, MN 55811		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 689	R26's medical chathe following falls: On 10/14/17, at 11 mat on floor next room. Was alert, shere, now I can't gable to move all easisted to stand room without prob. On 11/21/17, at 5 note (R26's medic of a fall one week at baseline, no resinjuries observed, assessment. On 12/13/17, at 5 witnessed fall. Pe was standing at na Another resident ther hand, and pull lower herself to the and stated, "I'm of apparent injuries. On 12/18/17, at 11 unwitnessed fall in heard walker fall or resident lying on rotified writer, and ROM to all extrem Writer assisted re was reported she last night. On 1/11/18, at 8:5 witnessed fall at a assessed residen lump to left side of however, when as left side of her her	art was reviewed and indicated	F6	689		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING			08/:	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZII 2501 RICE LAKE ROAD DULUTH, MN 55811	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
F 689	on head. Resident approximately 8:45 from Emergency Reshoulder and spine On 5/7/18, at 1:21 pin main dining room packages of sugar, hit her head on wal swelling on back of started, able to most took to bed and has Applied ice pack to minute checks On 5/29/18, at 10:4 on floor two separa buttocks, holding heresident's room sitt of resident. No injuminute checks initia On 7/13/18 at 7:10 resident in hall. Resident in hall. Resident and applied bent. Used Hoyer to Emergency Room in Resident returned a ambulance with panormal, and expect for the next few day at this time.  According to the fact 11/30/17, fell in and unnamed injury, at sent to Emergency 12/13/17, fell by nu	In for evaluation due to lump left via ambulance at a.m. At 11:09 received update com, CT [Cat Scan] of head, negative.  In m. R26 had an witnessed fall in next to counter where creamers, are located. She land railing. She has one inche her head. Neuro/vitals we all extremities, dry brief; is stayed in her bedroom. back of head. Placed on 15  5 p.m. Resident found sitting te times. #1. Sitting on floor on lead. #2. Found in another ing on floor with walker in front ry. Staff monitoring with 15	F6	89			

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	12/13/17, in another skin tear, at 8:20 p. to evaluate medica visit [there was no ibe there]. 1/11/018, in resider at 8:00 a.m. The intergency Room iblood pressure x 3 4/3/18, at nurse's dp.m. The intervention gripper socks ar 5/6/18, in main dini p.m. The intervention gripper socks ar 5/6/18, in hallway injury and 10:15 p.r. intervention was not medications. 7/13/18, at nurse's a.m. No interventio 7/13/18, in hallway were listed. R26 was Room and returned with no injuries per 8/10/18, at nurse's p.m. The interventio pressures and there R26's fall logs did redocumentation, and not coincide with the facility lacked a coccentered approach	m. The interventions was, MD tions at the next scheduled indication when MD-A would of the reventions listed were sent to for evaluation, orthostatic days, Debrox drops [for ears]. esk with no injury at 11:15 on was to remind staff to put individual with the reventions listed were sent to for evaluation, orthostatic days, Debrox drops [for ears]. esk with no injury at 11:15 on was to remind staff to put individual with the remind staff to put individual with the injury at 11:45 on was a 7 day sleep study. at 8:30 p.m. with unnamed in. with no injury. The orified MD in regards to fall, no instation with no injury at 11:15 ins were listed. at 7:10 p.m. No interventions as sent to the Emergency in at 112:30 a.m. on 7/14/18, CT scan. station, no injuries, at 6:10 on was 3 day orthostatic blood apy. In the redinated and resident to falls. Interventions Eating Skills	F 68			10/2/18
00-0	§483.25(g)(4)-(5) E (Includes naso-gas					

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F 693	percutaneous endo enteral fluids). Bas comprehensive as ensure that a reside §483.25(g)(4) A ree at enough alone enteral methods un condition demonst clinically indicated resident; and §483.25(g)(5) A remeans receives the services to restore and to prevent conincluding but not lindiarrhea, vomiting, abnormalities, and This REQUIREME by:  Based on observatives of the service of t	oscopic jejunostomy, and sed on a resident's sessment, the facility must	F 69		given		
	reviewed for tube for Findings include: R148's admission dated 8/15/18, indiversity dysphagia (difficult injury (TBI) and muthe MDS identified R148's Physician CR148 had an order	e for 1 of 2 residents (R148) reedings.  Minimum Data Set (MDS) cated diagnoses that included by swallowing, traumatic brain cuscle weakness. In addition, R148 received tube feeding.  Order dated 8/8/18, indicated for Jevity 1.0 (nutrition for nilliliter (ml) per/hour for 21		" Other residents with tube feel receiving the feeding as order medications are given according standards of practice.  " Licensed nurses have been regarding facility expectations feeding services and medicating administration.  " Licensed nurses have been regarding tube feeding policy of feeding medication administration.  " Observational audits of medical administration through a g-tube conducted with nursing staff to	ed, and ing to re-educated for tube on re-educated and tube ation policy. ication be are		

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F 693	hours continuous addition, a physic R148 was to rece gastrostomy (g) to 600 ml.  R148's care plan did not receive ar received tube fee nursing was to ac free water flushes follow facility tube medications were physician order.  On 8/22/18, at 8:0 was observed pre RN-D crushed se separate plastic be powdered Potass (mEq) in five oun was going to give At 8:11 a.m. RN-I to the bathroom a graduate cylinder indicated she was medications and g-tube. RN-D pull down the small cumixed in water, a medications crus applying gloves, is removed the tab with air into the festethoscope to che clamped the g-tul then separated the inserted the barres	ly from 8:00 a.m. to 5:00 a.m. In ian order dated 8/9/18, indicated live 150 ml water flushes via ube four times daily for a total of dated 8/16/18, indicated R148 hything by mouth, and she ding. The care plan indicated liminister the tube feeding and a via g-tube, nursing was to refeeding policy/protocol, and administered via g-tube per load a.m. registered nurse (RN)-D reparing R148's medications. In loags and mixed two packets of lium Chloride 20 milliequivalent loads and mixed two packets of lium Chloride 20 milliequivalent loads of water. RN-D stated she wall the medications via g-tube. Do arrived at R148's room, went land obtained 200 ml of water in a land. RN-D approached R148, as going to administer start her enteral feeding via led the bedside table and set up with Potassium Chloride and the rest of R148's morning led in little plastic bags. After RN-D was picked up the g-tube, closure, and inserted a syringe reding port as she listened with a lanck for tube placement. RN-D load, took the syringe off the port, lie barrel and plunger. RN-D led into the g-tube port and lof water, clamped the g-tube, closure, clamped the g-tube, linto the g-tube port and lof water, clamped the g-tube, linto the g-tube port and lof water, clamped the g-tube, linto the g-tube port and lof water, clamped the g-tube,	F 6	medications given according for practice. These audits completed by ADON or Nutwo audits weekly x4, then every other week x2, then the QAPI.	will be urse Manager i two audits	

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F 693	barrel and flushed clamped the g-tube water into the barre medication powder and released it to a RN-D followed this RN-D repeated this crushed powdered mixing the medicat them into the barre into the bathroom a water. RN-D return flushed the tube. R the crushed powde separate occasions RN-D stated she has water to complete tremoved her gloves of water, cleansed without starting R14 At 8:25 a.m. RN-D orders and verified water flushes four thad given R148 more problem with medications settle. mixed the medicati them, because she her she would pour barrel with water 5 follow with a water RN-D stated she difeeding, and that we	um Chloride liquid into the with 10 ml of water. RN-D and poured another 10 ml of el. RN-D emptied the crushed into the water in the barrel, adminsitered the medications. With a 10 ml flush of water. Sprocess of emptying the medications five times without ions with water before pouring I. Once finished, RN-D went and obtained another 200 ml of ed to R148's bed side, and N-D continued to administer and medications on two stollowed by water flushes. and used a total of 350 ml of the water flushes. RN-D stated her remaining 50 ml her hands, and left the room 48's tube feeding.  Teviewed R148's physician R148 was to receive 150 ml of times a day. RN-D stated she per water because she had a cations not draining, and she off the tube feeding "To let the "RN-D stated she had not ons prior to administering had asked RN-E, who told the powder into the syringe ml to 10 ml of water, and then flush of the same amount. In the water she had asked RN-E and the was going to hold off on	F	693			

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F 693	using the little mediadministration. RN-not gotten the extra RN-E stated she was not running as have gotten an ordefrom the nurse prace R148's tube feeding from 8:00 a.m. to 5 continuously)  On 8/22/18, from 8 feeding was observed. At 9:02 a.m. RN-E had gotten an orde three hours due to would re-start the trough and the clinical check list.  On 8/22/18, at 1:40 had not demonstrate to medication administration administration administration administration to dissolve the mediadministering them The DON stated RI physician orders for have started the tules.	a.m. RN-E stated I have been dissolved in water ication cups before g-tube E stated R148 should have water (200 ml of water flush). as not aware the tube feeding ordered, and RN-D should er to hold the tube feeding citioner (NP). RN-E verified g was supposed to be running :00 a.m. (21 hours  :52 a.m. to 9:01 a.m. the tube yed not running.  approached and stated she r to hold the tube feeding for the extra water given and ube feeding 11:00 a.m.  p.m. RN-F verified the RN-D ted competency skills related nistration through a g-tube. licensed nursing staff had a  p.m. the director of nursing would have expected the nurse dications in water before according to the facility policy. N-D should have followed the r the water flushes, and should be feeding timely as ordered,	F 69	93		
	and if not, to get an Respiratory/Trache CFR(s): 483.25(i)	ostomy Care and Suctioning	F 6	95		10/2/18

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F 695	§ 483.25(i) Respi tracheostomy car The facility must on eeds respiratory care and tracheal care, consistent with practice, the composition care plan, the result and 483.65 of this This REQUIREM by:  Based on observing review, the facility was replaced in a clean a nebulizer reviewed for respiration for the provided in the clean and treatment of the control of the	ratory care, including e and tracheal suctioning. ensure that a resident who care, including tracheostomy suctioning, is provided such with professional standards of prehensive person-centered idents' goals and preferences, subpart. ENT is not met as evidenced ration, interview, and document of failed to ensure oxygen tubing a timely manner, and failed to mask for 1 of 1 resdients (R35) irratory care.  Ininimum Data Set (MDS) dated a R35 had intact cognition and e assitance with all activities of the pulmonary disease and administration record (MAR) ministration record (TAR) ft nurse to clean Bi-PAP (bilevel essure) machine every change nebulizer tubing and	F 6	F695  Respiratory Care:  "Oxygen tubing for R35 has replaced, and the nebulizer cleaned. This has been add treatment administration recreplacement. It is being cordocumented weekly.  "Other residents using oxygenebulizer treatments have the tubing replaced timely, and/masks cleaned.  "Residents receiving oxygenebulizer treatment have be to ensure that the tubing replacement/mask cleaning treatment administration recreplacement.  "Audits to monitor completed documentation of the tubing replacement/mask cleaning conducted by the Nurse Maaudits weekly x4, then two a other week x2, then as directions."	mask ded to the cord for weekly mpleted and gen and/or neir oxygen or nebulizer n and/or een reviewed is on the cord for weekly on and will be nagers two		

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F 695	observed in his root tubing was a piece nebulizer machine table. The mask wa and had visible corrodorn on 8/23/18, at 9:27 (LPN)-D sated the changing the oxygenebulizer machine after each use. She treatment was sche and she had not girstated whoever gas should have cleaned on 8/23/18, at 9:30 tubing should be reovernight shift. LPN machine mask shouse. He stated the supposed to change A facility policy titled April 2009, indicate tubing after use, shair dry the nebulize	mplaint.  B a.m. R35's oxygen tank was am. Attached to the oxygen of tape dated 7/21/18. R35's was sitting on top of a side as attached to the machine, adensation.  Y a.m. licensed practical nurse night shift was responsible for the tubing. LPN-D stated the was supposed to be cleaned as stated R35's nebulizer eduled to be given as needed, wen one on her shift. LPN-D we the last nebulizer treatment ed the machine.  D a.m. LPN-B stated oxygen eplaced weekly on the N-B stated the nebulizer nurses know they are use the tubing weekly.  I Nebulizer Therapy dated as taff should disconnect the take out the excess liquid, and r cup.	F 699			
F 725 SS=E		Staff 1)(2)	F 72	5		10/2/18

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F 725	The facility must I the appropriate or provide nursing a resident safety ar practicable physic well-being of each resident assessmand considering the diagnoses of the accordance with at §483.70(e).  §483.35(a)(1) The by sufficient numbers of personnenursing care to all resident care plar (i) Except when we this section, licen (ii) Other nursing limited to nurse at §483.35(a)(2) Except was a section, licen (iii) Other nursing limited to nurse at §483.35(a)(2) Except was a section, licen (iii) Other nursing limited to nurse at §483.35(a)(2) Except was a section, licen (iii) Other nursing limited to nurse at §483.35(a)(2) Except was a section, licen (iii) Other nursing limited to nurse at §483.35(a)(2) Except was a section, licen (iii) Other nursing limited to nurse at §483.35(a)(2) Except was a section, licen (iii) Other nursing limited to nurse at §483.35(a)(2) Except was a section, licen (iii) Other nursing limited to nurse at §483.35(a)(2) Except was a section of the licens of the	nave sufficient nursing staff with ompetencies and skills sets to and related services to assure and attain or maintain the highest cal, mental, and psychosocial in resident, as determined by tents and individual plans of care the number, acuity and facility's resident population in the facility assessment required the facility must provide services personed each of the following of on a 24-hour basis to provide I residents in accordance with the second set of the facility must provide under paragraph (e) of sed nurses; and personnel, including but not ides.  The provided under the facility must sed nurse to serve as a charge our of duty.  ENT is not met as evidenced the residents on the Cedar Unit. Intial to affect all 40 residents	F7	F725  Sufficient Nursing Meals are being served a posted schedule.  The DON and Nurse Mar reviewed the nursing assis The routines have been ad efficiency.  Resident 35 is encourage come out to the dining roor	ccording to the nagers have tant routines. justed for	

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F 725	evening meal was R35's 14 day Min 7/10/18, indicated impaired, and red and toileting.  During interview of stated he had a coin the morning. He bed, and sometime and he missed by happened recently and the missed by happened recently and the missed by happened recently and the missed by happened recently and 11 seconds.  R69's quarterly Mean had intact cognitical and 11 seconds.  R69's quarterly Mean had intact cognitical intact cognitical intact cognitical assistance with all the burning an interview p.m. family members facility a lot. FM-Elong time to be an it went for up to 2 answered. R69 sto the bathroom in R95's annual MD was severely cogextensive assistaliving. The MDS for the bathroom in R95's annual MD was severely cogextensive assistaliving. The MDS for the bathroom in R95's annual MD was severely cogextensive assistaliving. The MDS for the bathroom in R95's annual MD was severely cogextensive assistaliving. The MDS for the bathroom in R95's annual MD was severely cogextensive assistaliving. The MDS for the Bathroom in R95's annual MD was severely cogextensive assistaliving. The MDS for the Bathroom in R95's annual MD was severely cogextensive assistaliving. The MDS for the Bathroom in R95's annual MD was severely cogextensive assistaliving. The MDS for the Bathroom in R95's annual MD was severely cogextensive assistaliving. The MDS for the Bathroom in R95's annual MD was severely cogextensive assistaliving.	imum Data Set (MDS) dated the was moderately cognitively puired assistance for transfers on 8/20/18, at 6:28 p.m. R35 hallenge getting up for breakfast e stated he did not like eating in nes the facility was understaffed eakfast. He stated this had by.  ice activity report dated 8/19/18, all light was on 8/18/18, at 7:14 answered until 8:32 a.m. a total minutes. On 8/19/18, R35's call on at 7:05 a.m. and not 39 a.m. a total of 34 minutes  IDS dated 6/14/18, indicated he on, and required extensive activities of daily living.  ew with R69 on 8/20/18, at 1:59 over (FM)-B stated she was at the 3 stated R69's call light took a newered, and stated sometimes 5 minutes without being tated he almost always had to go	F 72	"Residents are encouraged to to the dining room for meals."  "Call lights are answered time R69, R11, R48, R150, R122 a residents.  "Resident 95 no longer residents.  "Nursing staff have been resident needs. If staff are unaresident needs, staff have been educated/instructed to notify the charge nurse or nurse manage."  Audits to monitor compliance conducted two audits weekly audits every other week x2, the directed by QAPI.	ely for R35, and all es at Chris educated for meeting able to meet en he unit er. e will be x4, then two		

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F 725	his favorite activitie 7/26/18, identified of disturbance, and di met his needs, offe and reorient as nee identified behaviors frustrated, especial staff did not responcheck for hunger, the During an observat R95 was in his whethe dining room. At the nurses station obrother. Licensed pR95 to give him a linumber for him. At himself down the him back into the dwas on, turned to a was again propellin At 7:46 a.m. R95 at open elevator door intervened and told aides. R95 asked Fher a name. At 7:5 escorted back a taken member, but was no linen napkin and a emptying the box of a.m. R95 propelled room table. At this to a country station at the table but no cresidents were sitting eyes closed, a four wheel chair with he	s. R95's care plan dated dementia with behavioral rected staff to anticipate and r choices regarding daily care eded. The care plan further that included: easily ly when R95 could not hear, or d quickly and directed staff to hirst, pain or activity needs.  ion on 8/22/18, at 7:05 a.m. elchair self-propelling around 7:12 a.m. R95 was in front of desk requesting to call his fractical nurse (LPN)- B told ttle bit, and he would find the 7:21 a.m. R95 was propelling allway. A staff member pushed ining room where a television talk show. At 7:39 a.m. R95 g himself in the dining room. Itempted to exit the unit via an Registered nurse (RN)-B him he needed his hearing RN-B who she was and called 0 a.m. R95 was again ble in the dining room by a staff not offered anything to eat or othing on the table except a box of tissues. R95 began f tissues onto the table At 8:05 himself away from the dining time, a radio was playing tuned the theorem of the dining room with their the resident was sitting in a rhands covering her face and it alone at a table with her	F 7	25			

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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 725	arms crossed in fattempt by staff to resdients during to R95 made another the elevator door not allow him to led button again and back to his table away. At 8:23 a.m table and headed a.m. the elevator attempted to exit the wall preventing the elevator door attempted to get back to the table R95 threw a naph seated at the table it to R95. R95 thresecond time and wheel chair to pict attempted to get the napkin. While fell onto his right on 8/22/18, at 9: breakfast meal or scheduled to beg R11's annual MD was cognitively in assistance for be transfers. The MI always continent .  On 8/21/18, at 2: (FM)-C stated she stated she had go	ront of her. There was no engage R95 or the other he observation. At 8:18 a.m. er attempt to exit the unit through. Staff again intervened and did eave. R95 pushed the elevator a staff member brought him in the dining room and walked in R95 propelled away from the back to the elevator. At 8:25 door opened and R95 but his wheel chair was stuck on in ghim from moving. At 8:27 a.m. opened again and R95 again in A staff member brought him in the dining room. At 8:33 a.m. cin on the floor. A resident in the picked up the napkin and gave ew the napkin under the table a attempted to stand up out of the k it up. At 8:36 a.m. R95 but of his wheel chair to pick up trying to kneel on the floor, R95 side on the floor.	F 7	725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245366	B. WING			08/	23/2018
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		250	REET ADDRESS, CITY, STATE, ZIP CODE D1 RICE LAKE ROAD JLUTH, MN 55811	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 725	how long his call lifelt like it affected to wait to use the assisted R11 to the would watch for the answer it. FM-C so for his call light to the bathroom wall disheartening whe another residents the wall. FM-C fur LPN-B not to assign because she endeand stated, "That's R48's annual MDS was moderately or extensive assitant mobility, transfers indicated R48 was and bladder.  On 8/22/18, at 1:4 (FM-D) stated she when she was not R48's face was not R48's face was not never brushed. FM at the facility to fin lying in a urine so stated the weeker another day she h R48's bed had urincomforter. FM-D so a specific staff me LPN-B several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competent one was overseein as several timestated she felt like lack of competen	ght stayed on, and stated she his quality of life when he had bathroom. FM-C stated staff e bathroom, and said they be call light, but would not tated if R11 had to wait too long be answered he would bang on a FM-C stated it was en she got to the facility and told her R11 was banging on ther stated she had asked gon the new staff to R11, and to wait to the stated she had asked gon the new staff to R11, and to wait too wait to wait too wait t	F 7	725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245366	B. WING		80	3/23/2018
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 725	everyone up to a roon 8/22/18, at 7:4 there were five NA morning, there we stated she was the morning and state LPN-C stated the acuity and stated, break."  On 8/22/18, at 1:2 usually four NA's sonurses. RN-B state breakfast at 9:00 at there were several room that day, the On 8/22/18, at 1:3 staffed based on the control of the staffing levels stated he had received additional aide for census dropped to scheduled. LPN-B the staffing levels stated he had received at the longer call light meal times.  A review of facility following:  5/8/18, R11 reported call light reported call light reported call light reported being the staff reported bei	_	F 72			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245366	B. WING_		08	/23/2018	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD  DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 725	received care when after his needs. The spoke with staff an important, and they prevent long call light of the answered. The audit was performed complaint. Call light facility would like. Spoke with staff on indicated facility wo with better options 8/2/18, R122 report answered in the aft to wait 45 minutes, did not come at all. performed and identify are too busy to form labeled Griev stated she did not stated it could have she had recently mindicated grievance taken.  During interview or stated, "I do rement on the true side."  On 8/23/18, at 1:20 recalled a concern FM-C. LPN-B states.	n she was in the facility to look be report indicated LPN-B d explained the call lights were by needed to work as a team to ght wait times.  Orted call lights took too long to report indicated a call light ed, and R150 had a legitimate ed, and stated sometimes staff to come up to meet resident needs.  Ited his call light was not being ternoon. R122 reported he had and stated sometimes staff. A call light audit was not filled a wait time of over 27	F 72	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08/	23/2018	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	stated when a fami concern he would to right away if he could the employee, but we document the convalue concern about the COn 8/23/18, at 3:01 director (HRD) and were interviewed. To morning to discuss and acuity changes expressed concernencouraged them to team lead. The DO were responsible for concerns by reside DON stated concernated to ensure for meals running late meals were running are still getting people aware they were a was typical to be rounded to b	stency in staffing. LPN-B ly member came to him with a ry to address it and correct it ild. He stated he would talk to would not necessarily ersation. LPN-B did not recall e NA by FM-D.  p.m. the human resources the director of nursing (DON) The HRD stated staff met every census, potential admissions, s. The HRD stated if staff s related to staffing levels, she to go to the nurse manager or N stated the nurse managers or following up on staffing ents, families and staff. The ens were documented and collow up. In regard to the con the units, the DON stated g late on units because NA's ple up. She stated she was little late, but did not realize it butinely late. g Staff 3)(4)(c)	F 726			10/2/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245366	B. WING		08/	23/2018	
	PROVIDER OR SUPPLIEF	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD  DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 726	at §483.70(e).  §483.35(a)(3) The licensed nurses had skill sets needs needs, as identified assessments, and §483.35(a)(4) Prolimited to assessir implementing resistor resident's needs for esident's needs for esident's needs, as identified assessments, and This REQUIREMED by:  Based on observareview, the facility nursing staff demore related to medicate tube feeding for 1 for tube feeding.  Findings include:  R148's admission dated 8/15/18, indiges include:  R148's admission dated 8/15/18, indiges include:  R148's Physician	re facility assessment required  a facility must ensure that ave the specific competencies essary to care for residents' d through resident described in the plan of care.  Aviding care includes but is not not not evaluating, planning and dent care plans and responding	F7	F726 □ Competent Nursing " R148 is receiving tube feed medication administration ad standards of practice. " Other residents with tube for receiving medication administration administration administration according to standards of pr " Licensed nurses have been regarding facility expectation medication administration the feeding. " Skills check off for administration through a tube for the properties of	ding and according to eedings are stration actice. In re-educated as for arough a tube stration of eeding has a r new hire		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08/	23/2018	
NAME OF I	PROVIDER OR SUPPLIEI	₹		STREET ADDRESS, CITY, STATE, ZIP (			
CHRIS J	ENSEN HEALTH & F	REHABILITATION CENTER		2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 726	tube feeding), 65 hours continuously addition, a physicial R148 was to receive the feeding of th	milliliter (ml) per/hour for 21 y from 8:00 a.m. to 5:00 a.m. In an order dated 8/9/18, indicated ive 150 ml water flushes via ube four times daily for a total of dated 8/16/18, indicated R148 ything by mouth, and she ding. The care plan indicated minister the tube feeding and a via g-tube, nursing was to feeding policy/protocol, and administered via g-tube per 04 a.m. registered nurse (RN)-D sparing R148's medications. In ags and mixed two packets of itum Chloride 20 milliequivalent ces of water. RN-D stated she all the medications via g-tube. Of arrived at R148's room, wented at R148's room, wented obtained 200 ml of water in a going to administer start her enteral feeding via the bedside table and set up with Potassium Chloride and the rest of R148's morning med in little plastic bags. After RN-D was picked up the g-tube, closure, and inserted a syringe eding port as she listened with a	F 7	skill of medication administ a tube feeding have been of licensed nurses.  "Observational audits by A designee will continue two x4 weeks, then two audits a other week x2, then as directions.	DON or audits weekly a week every		
	R148's care plan did not receive an received tube feed nursing was to ad free water flushes follow facility tube medications were physician order.  On 8/22/18, at 8:0 was observed pre RN-D crushed set separate plastic be powdered Potass (mEq) in five ound was going to give At 8:11 a.m. RN-E to the bathroom a graduate cylinder indicated she was medications and seg-tube. RN-D pulled down the small cumixed in water, and medications crush applying gloves, Fremoved the tab owith air into the festethoscope to che clamped the g-tube the separated the separated the segurater of the segurated in the separated the segurated the segura	dated 8/16/18, indicated R148 ything by mouth, and she ding. The care plan indicated minister the tube feeding and a via g-tube, nursing was to feeding policy/protocol, and administered via g-tube per of the decimal straight of the decimal straig		x4 weeks, then two audits a	a week every		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING		80	3/23/2018	
	PROVIDER OR SUPPLIER ENSEN HEALTH & R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 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 PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 726	poured the Potass barrel and flushed clamped the g-tub water into the barr medication powde and released it to RN-D followed this RN-D repeated this crushed powdered mixing the medicathem into the bathroom water. RN-D return flushed the tube. If the crushed powdeseparate occasion RN-D stated she hwater to complete removed her glove of water, cleansed without starting R1 At 8:25 a.m. RN-D orders and verified water flushes four had given R148 mproblem with mediwas going to hold medications settle mixed the mixed the medications settle mixed the mixed the mixed the mixed the mixed the mixed t	all of water, clamped the g-tube, ium Chloride liquid into the with 10 ml of water. RN-D e and poured another 10 ml of el. RN-D emptied the crushed r into the water in the barrel, adminsitered the medications. It with a 10 ml flush of water. It is process of emptying the limedications five times without tions with water before pouring el. Once finished, RN-D went and obtained another 200 ml of ned to R148's bed side, and RN-D continued to administer ered medications on two sofollowed by water flushes. It water flushes and left the room at the water flushes. It water flushes the feeding.  It reviewed R148's physician at R148 was to receive 150 ml of times a day. RN-D stated she ore water because she had a cations not draining, and she off the tube feeding "To let the in RN-D stated she had not it in the powder into the syringe end to 10 ml of water, and then affush of the same amount. It in the was why she had asked RN-E. It was going to hold off on	F 7	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED	
		245366	B. WING		/23/2018	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	not demonstrated of medication administrated all the licensic check list. RN-F stathe same clinical retreatment/Service CFR(s): 483.40(b)(s) §483.40(b)(s) A residiagnosed with demappropriate treatment maintain his or hermental, and psychothis REQUIREME by: Based on observative review, the facility from the services were proving reviewed for deme.  Findings include:  R95's annual Minimal 7/25/18, indicated limpaired, and requall activities of daily indicated it was verable to participate in care plan dated 7/2 behavioral disturbaticipate and met regarding daily care care plan further identification.	p.m. RN-F verified RN-D had competency skills related to stration through a g-tube. RN-F sed nursing staff had a clinical ated both LPN's and RN's had equirements in the checklist. for Dementia  3)  sident who displays or is mentia, receives the ent and services to attain or highest practicable physical, associal well-being.  NT is not met as evidenced ation, interview and document ailed to ensure dementia ided for 1 of 3 residents (R95) makes a severely cognitively ired extensive assistance with a living. The MDS further by important to R95 that he was not his favorite activities. R95's end reorient as needed. The entified behaviors that	F 744	F744 Dementia Services:  "Resident 95 no longer resides at Chris Jensen.  "Other residents with dementia are receiving dementia services according to assessment and plan of care.  "Staff have been re-educated regarding facility expectations to engage residents with dementia.  "Nursing staff have been re-educated regarding facility expectations for appropriate verbal response to a fall in residents with dementia.  "Staff have been re-educated regarding	10/2/18	
	could not hear or s	strated, especially when R95 taff did not respond quickly o check for hunger, thirst, pain		the Behavioral Health Policy in reference to Dementia Services facility expectations		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING			08/2	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD ULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 744	or activity needs.  On 8/22/18, at 7:05 wheelchair self-pro room.  At 7:12 a.m. R95 w station desk request Licensed practical rhim a little bit, and him.  At 7:21 a.m. R95 w hallway. A staff meddining room where a talk show. At 7:35 propelling himself in At 7:46 a.m. R95 at open elevator door, intervened and told aides. R95 asked Fher a name. R95 w table in the dining rwas not offered any was nothing on the and a box of tissue box of tissues onto propelled himself at table. At this time, a other men were sitt was talking. Three the dining room wit resident was sitting hands covering her alone at a table with her. There was no a or the other resdier	a.m. R95 was observed in his pelling around the dining as in front of the nurses sting to call his brother. The nurse (LPN)-B told R95 to give the would find the number for as propelling himself down the mber pushed him back into the a television was on, turned to a.m. R95 was again	F 7	44	"Activity calendar for Cedar and W has been reviewed and revised if indicated with an emphasis on assi with engagement and dementia set."  "Observational audits to monitor for interaction and engagement on the staff with residents requiring demenservices will be conducted by the A Director or designee in collaboration the nurse manager. These audits occur two audits weekly x4 weeks, two audits every other week x2, the directed by QAPI.	sting rvices. or part of ntia ctivity n with will then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING	·		08/:	23/2018
	PROVIDER OR SUPPLIER  ENSEN HEALTH & RE	EHABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 744	unit through the eleintervened and did pushed the elevator member brought hidining room and was away from the table elevator. The eleva attempted to exit but the wall preventing elevator door open attempted to get in back to the table in napkin on the floor. picked up the napk threw the napkin ur and attempted to sit to pick it up. At 8:36 out of his wheel on the side on the floor. Listated to R95, "You you?" LPN-C then smember, "He so did turned to R95 and a himself on the floor. Listated to R95 and a himself on the floor lying on the floor. Listated to R95 and a himself on the floor lying on the floor. Listated to R95 and a himself on the floor lying on the floor. Listated to R95 and a himself on the floor lying and asked what this time, R95 restaff members stansigns of agitation. It squeezed LPN-C's other hand and stannurse practitioner will ying and asked what R95 put himself on been wild all night, punch staff. During	vator door. Staff again not allow him to leave. R95 r button again and a staff m back to his table in the alked away. R95 propelled and headed back to the tor door opened, and R95 ut his wheel chair was stuck on him from moving. The ed again, and R95 again  A staff member brought him the dining room. R95 threw a A resident seated at the table in and gave it to R95. R95 nder the table a second time and up out of the wheel chair is a.m. R95 attempted to get air to pick up the napkin. While he floor, R95 fell onto his right PN-C responded to the fall and did that on purpose didn't estated to another staff d that on purpose." LPN-C again asked him why he put and the staff and hand, pointed at her with the ding over him. R95 displayed the attempted to hit staff and hand, pointed at her with the ed, "It was you." The certified walked over to where R95 was at happened. LPN-C stated the floor, and stated he had throwing things and trying to the observation there were no offer R95 fluids, food, toileting	F	744			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08	/23/2018	
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 2501 RICE LAKE ROAD DULUTH, MN 55811	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 744	On 8/23/18, at 9:4 stated R95 had a behaviors include and stated staff keeping him there the nurse. NA-B s was able to compand stated his behavior such as getting himake him more compands the enditor of the enditor o	19 a.m. nursing assistant (NA)-B lot of behaviors. She stated his d putting himself on the floor, eep him by the nurses station. Ity R95 got mad that staff were a, and he threw a Kleenex box at tated she did not know if R95 rehend what was happening, lerstands simple cues. She or interventions included things m something to eat or trying to	F7	'44			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08	/23/2018	
	PROVIDER OR SUPPLIER ENSEN HEALTH & RI	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 744	interest information He stated the beha developed by the ir stated staff know to that have helped w LPN-B stated R95 the phone to call hi has been declining stated if R95 was b stuff, staff would pe solarium and give h needed. He stated they were suppose medication aide, ar intervention.	n should be on the group sheet. Avioral care plan was interdisciplinary team. LPN-B to ask questions about things ith R95's behaviors in the past. It was constantly asking to use is daughter, but the daughter that as an intervention. LPN-B being aggressive or grabbing ersuade him to go to the mim time to express what he if staff needed interventions it do go to the nurse or trained and they would come up with an ited to dementia care was received.	F 74			10/2/18	
SS=D	§483.45(g) Labeling Drugs and biological labeled in accordar professional principal appropriate access instructions, and the applicable.  §483.45(h) Storage §483.45(h)(1) In acceptance laws, the fabiologicals in locked temperature control personnel to have a	g of Drugs and Biologicals als used in the facility must be note with currently accepted bles, and include the sory and cautionary e expiration date when e of Drugs and Biologicals accordance with State and acility must store all drugs and d compartments under proper bls, and permit only authorized					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN			(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08/23/2018		
	NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 761	locked, permanen storage of controll the Comprehensiv Control Act of 197 abuse, except who package drug distinguantity stored is to be readily detected. This REQUIREMED by:  Based on observative review, the facility medications were 2 of 5 medication storage.  Findings include:  On 8/23/18, at 1:0 cart was observed (LPN)-D. The cart stock medications (milligrams) expired expiration dates, a residents received. On 8/23/18, at 1:1 cart was observed. The cart contained medication: 2 bott on 1/18, and 1 bot 1/18. RN-B verified stated she didn't the receiving those medications medications medications and the cart contained medication of the cart contained m	tly affixed compartments for ed drugs listed in Schedule II of the Drug Abuse Prevention and and other drugs subject to the facility uses single unit ribution systems in which the minimal and a missing dose cand. The second of the facility uses single unit ribution systems in which the minimal and a missing dose cand. The second of the	F 76	F761 □ Drug Label/Storage:  "The bottles of over the counter stomedications that were in the medications that were in the medication and past their expiration date were removed and appropriately discard.  "The supply of over the counter stomedications in the medication cart medication rooms, and central suphave been checked to ensure there no medications past their expiration.  "All medications no longer being administered to residents are removed appropriately discarded.  "Licensed nurses and TMAs have re-educated about facility expectate checking all medications to include the counter stock medications for expiration date prior to medication administration.  "Over the counter stock medication have been specifically added to the used for routine audits of expiration.	carts led. ock s, ply e are n date. oved been ions for e over		
	revised March 1, 2 which are no longer	2014, directed all medications er being administered to the emoved and appropriately		on medications stored in the med of a stored	carts.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		<b>245366</b> B. WING		08/	23/2018		
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2501 RICE LAKE ROAD DULUTH, MN 55811			
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F 761	until destroyed.  2. All medications expiration date on tand re-ordered, if n 3. Rarely used PF needed, medication year from the date has an earlier expiration must be discontinued.  4. Medications are with state and federations are family unless there	d medications are kept locked which have passed the the label are properly disposed accessary. RN (pro re nata), i.e., as are not kept longer than one of issue on the label, unless it ration date. The PRN available until the order is the disposed of in accordance	F 76	two audits weekly x 4 weeks, t audits every other week X2 the directed by QAPI. The nurse is or designee are responsible for	en as managers		
	on 8/24/18, the polimedications.  Nutritive Value/App CFR(s): 483.60(d)(  §483.60(d) Food ar	nd drink	F 80	4		10/2/18	
	§483.60(d)(1) Food conserve nutritive v §483.60(d)(2) Food attractive, and at a temperature. This REQUIREMENT by:	d prepared by methods that value, flavor, and appearance; d and drink that is palatable, safe and appetizing  NT is not met as evidenced tion, interview, and document		F804 □ Food temps:			

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F 804	review, the facility served at a palata for 1 of 6 residents. Findings include: R4's Admission Re R4 had diagnoses dementia and Alzh R4's quarterly Min 5/3/18, indicated Femental status, and and encouragemental status, and encouragemental edentulous (lackin low sodium, low fatherner taken for encouragemental status, and encouragemental edentulous (lackin low sodium, low fatherner taken for encouragemental edentulous (lackin low sodium, low fatherner taken for encouragemental edentulous (lackin low sodium, low fatherner taken low fatherner taken direction encouragemental edentulous (lackin low sodium, low fatherner taken low fatherner taken direction encouragemental edentulous (lackin low sodium, low fatherner taken l	failed to ensure food was ble and appetizing temperature is (R4) receiving pureed food.  ecord printed 8/23/18, indicated is that included unspecified neimer's disease.  Immum Data Set (MDS) dated R4 had moderately impaired direquired set up assistance, ent or cueing with eating.  Ited 4/08/18, directed a low salt sterol 3 gram sodium diet. R4's 8/16/18, indicated R4 was ag teeth) and received a pureed, at, low cholesterol diet with equids.  If p.m. the supper food en by dietary aide (DA)-A es at 135 degrees Fahrenheit otatoes at 132 degrees F prior service. No action was taken to erature of these menu items. In meals at 5:25 p.m.  If p.m. as the last food trays sidents, pureed meatloaf erature of 100 degrees F, and as 110 degrees F with DA-B. Is were not observed to have the meal service and action to	F8	"Food temp logs for 8/20/1 temps prior to beginning of include: French fries at 17 mashed potatoes at 152 de "Pureed food temps on 8/2 pm were taken after all the had been served and the for empty except for small amount off the sides of the tray per request for pureed temp. "Food is served at a palata appetizing temperature for residents receiving pureed "Procedure for ensuring the served maintains temperate degrees or above was revieupdated. "Mid-meal temperature rea added to the process to maintenance of food tempe "Dietary staff have been re regarding the procedure for the food temperature durin service, and the addition of temperature readings. "Dietary Director or design initial and mid-meal temper week for 4 weeks; then 2 ti 2 weeks; then 1 time a wee then as directed by QAPI.	meal service 0 degrees, and egrees. 22/18 at 1:20 pureed foods ood tray was ounts scraped surveyor able and R4 and other food. at hot food ure of 140 ewed and ading was onitor eratures. e-educated r maintaining g steam table f mid-meal alee will audit ratures 3 x mes a week for		

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F 804	(DM) stated when f in the dining rooms supposed to call the	_	F 804	1		
F 809 SS=D	re-heat it. Frequency of Meals	s/Snacks at Bedtime	F 809		10/2/18	
	facility must provide regular times comp the community or in	resident must receive and the e at least three meals daily, at earable to normal mealtimes in accordance with resident s, requests, and plan of care.				
	hours between a subreakfast the follow nourishing snack is hours may elapse b	must be no more than 14 ubstantial evening meal and ving day, except when a served at bedtime, up to 16 between a substantial evening the following day if a resident s meal span.				
	meals and snacks who want to eat at of scheduled meal the resident plan of This REQUIREMEI by: Based on observation	NT is not met as evidenced tion, interview, and document		F809 □ Frequency of meals/HS sr		
	evening snacks we (R128, R4, R118) v	ailed to ensure substantial re offered for 3 of 3 residents who received meals in the com and who were reviewed		<ul><li>" Meals are being served according posted schedule.</li><li>" R128 is offered a beverage or a s seated in dining room early prior to</li></ul>	nack if	

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F 809	for dining services Findings include: In the Cedar unit, -Breakfast: 8:20 a -Lunch: 12:20 p.n -Dinner: 5:00 p.m There were 15 ho posted dinner and R128's Admissior indicated R128 ha dementia with bel weakness. R128's Order Sur indicated R128 w R128's quarterly I 8/8/18, indicted R cognition, was so others and was so understood. R128 required extensiv daily living (ADLs weighted 114 pour R128's care plan had lost weight du a body mass inde acceptable range calorie foods and medication pass to On 8/22/18, at 7:0 her wheelchair, in	the posted meal times were: a.m.  a.  burs, 25 minutes between the d breakfast times.  Record dated 8/23/18, ad diagnoses that included haviors, anemia, and muscle  mmary Report, dated 8/23/18, as to receive a pureed diet.  Minimum Data Set (MDS) dated 128 had severely impaired metimes able to understand ometimes able to be 8's MDS further indicated R128 as assistance with all activities of including eating, and she ands.  dated 5/5/18, indicated R128 uring the last 3 years resulting in ax (BMI) at the lowest of an ax (BMI) at the l	F8	609	meal, or if there is a delay in mealti "R4, R118 and R128 are offered nourishing snacks at bedtime. "The process for offering, providin documenting HS snacks has been reviewed and revised. "Nursing staff and Dietary staff has educated on the HS snack system, regarding facility expectation for off nourishing snacks at bedtime. "Observational audits of HS snack process will be conducted by PM N Supervisors two audits weekly x 4, two audits every other week x2, the directed by QAPI.	g and  /e been and fering  urse then	

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F 809	her wheelchair in not seated at a ta juice. R128 was a beverage or an accontinued to sit in grinding her teeth pushed in her who window. R128 was food item. From 9 was observed with At 9:22 a.m. a sta R128 to eat her b. At no time was R: snack to tide her creceived her brea 57 minutes past to the Cedar Unit brown, 22 minutes the Cedars unit.  Review of R128's printed 8/23/18, ir needed (PRN). R she had 1 bedtimbefore supper), 1 supper), and none R4's Admission R R4 had diagnoses dementia, Alzheir (difficulty swallow R4's quarterly Mir	17 a.m. R128 was observed in the unit dining room. R128 was ble, and did not have coffee or not approached, offered a civity at any time. R128 her wheelchair, sometimes until 8:59 a.m., when R128 was eelchair to at table near the s still offered no beverage or 0:07 a.m. until 9:20 a.m., R128 her head forward as if dosing. If person sat down to assist reakfast.  128 offered coffee, juice, or a over until breakfast. R128 kfast meal at 9:22 a.m., which is he posted time of 8:25 a.m. for eakfast meal. This was 16 after the posted dinner time for Documentation Survey Report adicated HS snacks are as 128's documentation indicated e (HS) snack in June (but HS snack in July (before a in August.	F8	809			

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F 809		•	F 80	99			
		ed 4/08/18,was for a low salt terol 3 gram sodium.					
	edentulous (no tee	ted 8/16/18, indicated R4 was th), and received a pureed, low v cholesterol diet with honey					
	not received. The	ords for R4 were requested but written request was returned s snacks consumed by R4 were					
		Record dated 8/23/18, I diagnoses that included sphagia.					
	02/02/18, indicated	imum Data Set (MDS) dated I R118 needed extensive ting with one person providing e.					
	required extensive nutrition portion of intervention of exte	ated 2/5/18, indicated R118 assist of one for all meals. The the care plan included ensive hands-on assistance to finish the meal, and instruction t side to assist.					
	8/22/2/18, were red indicated R118 ate on 8/3/18. The Doo provided for July 20 one evening snack	ack records from 7/1/18 - quested. Records provided an evening snack at 9:50 p.m. cumentation Survey Report 018, indicated that R118 ate at 8:33 p.m. and 4 snacks of 10:00 p.m. and 6:00 a.m.					
	On 8/23/18, at 3:13	B p.m. nursing assistant (NA)-J					

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F 809	hungry during the something to eat. If for special diets, are refrigerator to see specifically for that made an effort to get specific snack order to the recipients be she knew who ate them sitting outside resident couldn't fewith the resident at what was eaten for On 8/23/18, at 3:13 (LPN)-L stated statifuice to residents. If do not want an every ended around 6:00 residents do get event and the state of	resident stated they were evening, she would give them NA-J stated she would check and look in the back room if they had a labeled snack individual. NA-J said she give the labeled snacks, ers for example, for diabetics, etween 7-8 p.m. NA-J stated an evening snack by seeing a their room eating, or if a seed themselves, she would stay and then record in the computer	F 80	09			

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F 809	8/13/18.  The facility policy 1/27/18, directed residents as substant breakfast the following snack is offered to policy directed the and offering such 16 hours between following day break the policy, was resevening snack, and snack in the electron offered an HS snafacility would have the residents awar supper snacks wo	Meal Times/Frequency dated no more than 14 hours elapse ntial evening meal, and wing day unless a nourishing presidents at bedtime. The facility offer nourishing snacks, snacks allows there to be up to the evening meal and the kfast meal. Nursing staff, per sponsible for offering and for documentation of the conic record.  Hour of Sleep (HS) Snack and each resident would be ck. The policy directed the snacks available, and make the of that availability. After and words we have available at the	F 80	09			
	snacks were to be record. Assistive Devices CFR(s): 483.60(g) §483.60(g) Assisti The facility must p and utensils for re appropriate assist can use the assist meals and snacks This REQUIREME by: Based on observareview, the facility	ve devices rovide special eating equipment sidents who need them and ance to ensure that the resident ive devices when consuming	F 8	F810 □ Eating equipment/assis devices:  " The plan of care for R117 has		10/2/18	

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F 810	indicated R117's di (difficulty swallowin lung.  R117's admission I dated 5/4/18,indicadue to sequencing coordination. The N required assistance mechanical soft coground, pureed footbreak apart without was to work toward independence with On 5/4/18 a Physic Therapy form instruscoop plate [plate vindependence with Scoop plate [plate vindependence]."  R117 was observed 8/20/18, for the break/22/17, for the break/22/18, at 8:25 verified R117 had rung on the services (DD) indicated or an order was called modifies the Adapt information they get	r nutrition.  Record printed on 8/23/18, agnoses included dysphasia g) and cancer of throat or  Minimum Data Set (MDS) ted R117 had difficulty eating errors and declining MDS further identified R117 e with eating, required a nsistency diet (chopped, ids, and foods that readily to a knife). R117's goal listed if resident highest level of eating.  Ital, Occupational and Speech cucted: "Pt [patient] to use with elevated edges] at all of for meals on:  Independent of the ordered scoop of the coordinate of the ordered scoop of the coordinate of the co	F8	10	reviewed in regard to assistive dev with eating, revised if indicated, an is receiving the assistive device acto plan.  " Other residents who are identified needing special eating equipment utensils are receiving this equipmed devices according to plan.  " Nursing staff have been re-educate regarding the system for identifying assistive devices for eating, as well importance of ensuring these device provided according to plan.  " Observational audits to monitor for compliance will be conducted by the manager or designee two audits with x4, then two audits every other were then as directed by QAPI.	d R117 cording d as or ent or ated g ll as the ces are or ne nurse eekly	

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F 810	Ocontinued From page 68 changes have to be caught, or recommended by nursing assistants (NA) to help residents continue to be as independent as possible.		F 810			
	Food Procurement, CFR(s): 483.60(i)(1)  §483.60(i) Food sat The facility must -  §483.60(i)(1) - Procuper of the facility must -  §483.60(i)(1) - Procuper of the facility must -  §483.60(i)(1) - Procuper of the facility must -  (ii) This may include from local producer and local producer and local laws or refull (ii) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for \$483.60(i)(2) - Stor serve food in according standards for food satisfactory.	store/Prepare/Serve-Sanitary )(2)  fety requirements.  cure food from sources ered satisfactory by federal, rities. e food items obtained directly rs, subject to applicable State egulations. oes not prohibit or prevent produce grown in facility compliance with applicable bod-handling practices. loes not preclude residents ods not procured by the facility. e, prepare, distribute and dance with professional	F 812		10/2/18	
	Based on observation failed to ensure prostainless steel service formation and potential deficient practice has 165 residents who kitchen.	tion and interview, the facility oper drying and storage of ing pans to prevent bacteria ntial for foodborne illness. This ad the potential to affect all ate food prepared in the facility p.m. during the initial		F812 ☐ Kitchen sanitation:  " Stainless steel serving pans are thoroughly cleaned, properly air drie stored to ensure they are not put awwet.  " An additional drying rack was place the kitchen to expand drying space.  " The policy for cleaning and proper drying pots and pans has been revie and updated.  " Dietary staff have been re-educate	ed in ly air ewed	

AND DUAN OF CORRECTION IN INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	observation of the k manager (DM), four pans were checked pots and pans sink, away wet. Two morin the cooks area wet. The DM verificated before being some of the known of the	citchen with the dietary r stainless steel steam table I in the storage area near the Two of the pans had been put e stainless steel pans stored were also found to be stored ed the pans were put away to stated the pans were to be air stacked for use.  p.m. during a second citchen, four stainless steel I on a storage shelf in the four pans, one pan was noted her had been put away with hing on the pan surface. The pans and the soiled pans. Identifiable Information (5), 483.70(i)(1)-(5)  Ident-identifiable information. It release information that is to the public. The properties of the public of the	F 84		the facility expectation for thorough cleaning, properly air drying and sto pots/pans so they are not put away "Audits will be conducted by Dietar Director or designee 3 x weekly for weeks, then 2 times weekly for 2 withen one time a week for 2 weeks, directed by QAPI.	oring wet. y 4 eeks, then as	10/2/18

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F 842	(iv) Systematically §483.70(i)(2) The all information corregardless of the frecords, except w (i) To the individual representative wh (ii) Required by La (iii) For treatment, operations, as perwith 45 CFR 164.5 (iv) For public hean eglect, or domest activities, judicial alaw enforcement purposes, research medical examiner a serious threat to by and in compliant §483.70(i)(3) The record information unauthorized use. §483.70(i)(4) Med for- (i) The period of ti (ii) Five years from there is no require (iii) For a minor, 3 legal age under Si §483.70(i)(5) The (i) Sufficient inform (ii) A record of the	facility must keep confidential stained in the resident's records, form or storage method of the hen release isal, or their resident ere permitted by applicable law; aw; payment, or health care mitted by and in compliance 506; Ith activities, reporting of abuse, tic violence, health oversight and administrative proceedings, purposes, or gan donation the purposes, or to coroners, so, funeral directors, and to avert to health or safety as permitted ince with 45 CFR 164.512.  Ifacility must safeguard medical against loss, destruction, or it ical records must be retained me required by State law; or in the date of discharge when ement in State law; or years after a resident reaches	FE	342			

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		245366	B. WING		08/2	23/2018
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	and resident revie determinations co (v) Physician's, nu professional's pro (vi) Laboratory, ra services reports a This REQUIREME by: Based on intervie facility failed to ma complete medical status for 3 of 36 reviewed for advarsional facility failed to ma complete medical status for 3 of 36 reviewed for advarsional facility failed to ma complete medical status for 3 of 36 reviewed for advarsional facility failed to ma complete medical status for 3 of 36 reviewed for advarsional facility failed to ma complete medical status for 3 of 36 reviewed for advarsional facility failed to ma complete medical status for 3 of 36 reviewed for advarsional facility failed for advarsional facility failed for advarsional facility failed for advarsional failed failed for advarsional faile	any preadmission screening w evaluations and nducted by the State; arse's, and other licensed gress notes; and diology and other diagnostic s required under §483.50. ENT is not met as evidenced and document review, the aintain an accurate, and record related to resuscitation residents (R72, R4, R118)	F 8	F842  Medical Records:  "The resuscitation code stainformation located in the electronic record for F72, R4 and R118 removed during the survey.  "All resident electronic recoreviewed to ensure there was conflicting information presecompared to the POLST which source document for resusciat Chris Jensen.  "Licensed nurses and Healt Coordinators have been rethe primary source of resuscinformation is the POLST. signed by the resident/family reviewed and signed by the  "In review of this process we Medical Director, the POLST the source document. The status will not be entered as order into the electronic recorder into the electronic recorder into the front of the ham "Licensed nurses, TMAs, a Coordinators have been recregarding facility process of	ectronic 8 was  ords were as no ent as ich is the citation status  th Unit educated that citation This POLST is y, and also physician.  orth the T will remain resuscitation is a physician ord but will rd copy chart.  nd Health Unit educated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		E SURVEY PLETED
		245366	B. WING_		08/:	23/2018
	PROVIDER OR SUPPLIER  ENSEN HEALTH & R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 842	Continued From pa	age 72	F 84	POLST and the nurse tersource document and the for resuscitation status.  " Audits of consistent inforegarding resuscitation sweekly two audits x4 were audits every other week, by QAPI. Audits will be onurse managers.	e quick identifier ormation tatus will occur eks, then two then as directed	

	(X3) DATE SURVEY COMPLETED	
245366 B. WING 08/23/2	/2018	
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD  DULUTH, MN 55811		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTION SHOULD BE DEFICIENCY)	(X5) OMPLETION DATE	
F 842 Continued From page 73 F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08	/23/2018
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP C 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 842	Continued From p	page 74	F 84	42		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
	245366	B. WING		08/	/23/2018
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABI	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842 Continued From page 75		F 84	2		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
<b>245366</b> B. WING	08/23/2018
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER  STREET ADDRESS, CITY, STATE,  2501 RICE LAKE ROAD  DULUTH, MN 55811	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN O PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLÉTION DATE
F 842 Continued From page 76 F 842	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
	245366	B. WING	B. WING		/23/2018	
NAME OF PROVIDER OR SUPP	LIER & REHABILITATION CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CO 501 RICE LAKE ROAD DULUTH, MN 55811			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842 Continued From	m page 77	F 842				

	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245366	B. WING		08/23/2018	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD  DULUTH, MN 55811	,	
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F 842	Continued From p	page 78	F 84	2		

	MENT OF DEFICIENCIES AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT COM	(X3) DATE SURVEY COMPLETED		
		245366	B. WING		08/23/2018	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD  DULUTH, MN 55811	1 00.	
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F 842	Continued From p	Page 79	F 842	2		

	(X3) DATE SURVEY COMPLETED	
245366 B. WING 08/23/2	/2018	
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD  DULUTH, MN 55811		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 842 Continued From page 80 F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08/	/23/2018	
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 842 C	ontinued From p	age 81	F 84	42			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER ID PLAN OF CORRECTION IDENTIFICATION NUM			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245366			B. WING		08/23/2018	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD DULUTH, MN 55811	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 842	Continued From pa	age 82	F 842			

	(X3) DATE SURVEY COMPLETED	
245366 B. WING 08/23/2	/2018	
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD  DULUTH, MN 55811		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE DEFICIENCY)	(X5) COMPLETION DATE	
F 842 Continued From page 83 F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3) DA	TE SURVEY MPLETED
		245366	B. WING		08	/23/2018
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 842	Continued From p	page 84	F 84	42		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DAT COM	E SURVEY MPLETED
	245366	B. WING		08/	/23/2018
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2501 RICE LAKE ROAD DULUTH, MN 55811		
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F 842 Continued From page 88	5	F 84	2		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08/	23/2018	
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER	·	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 842	Continued From pa	ge 86	F 84	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08	3/23/2018	
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP 2501 RICE LAKE ROAD DULUTH, MN 55811			
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F 842 Continued	From p	age 87	F8	42			

1	(X3) DATE SURVEY COMPLETED	
245366 B. WING 08/23/2	2018	
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD  DULUTH, MN 55811		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) OMPLETION DATE	
F 842 Continued From page 88 F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3) DAT	E SURVEY MPLETED
		245366	B. WING		08.	/23/2018
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 842	Continued From p	page 89	F 8	42		

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		245366	B. WING		08/23/2018	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD  DULUTH, MN 55811	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 842	Continued From p	page 90	F 842			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL IDENTIFICATION N			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
245366			B. WING		08/	08/23/2018	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD DULUTH, MN 55811	1 30.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 842	Continued From pa	age 91	F 842				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08/	23/2018	
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER	·	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 842	Continued From pa	ge 92	F 84	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DAT COM	E SURVEY IPLETED	
	245366	B. WING _		08/	08/23/2018	
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REF	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2501 RICE LAKE ROAD DULUTH, MN 55811			
PREFIX (EACH DEFICIENCY I	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE APPLICATION OF	SHOULD BE	(X5) COMPLETION DATE	
F 842 Continued From pag	e 93	F 84	2			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245366	B. WING		08	/23/2018
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 2501 RICE LAKE ROAD DULUTH, MN 55811		120/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 842	Continued From	page 94	F8	342		
	R4's diagnoses in disease, acute kidobstructive pulmod R4's quarterly Min 5/3/18, indicated A review of R4's p POLST dated 7/3 practitioner 8/3/18 resuscitation state A review of active record for R4 incl 4/8/18, for Full Co 7/30/18, for DNR.	nimum Data Set (MDS) dated R4 was cognitively impaired.  paper medical record included a 0/18, and signed by a nurse B, indicating R4's wish for his us to be DNR.  corders in the electronic health uded an active order dated ode, and an active order dated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  IG	` ,	(X3) DATE SURVEY COMPLETED	
		245366	B. WING _		08	/23/2018
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 842	A review of the teastatus to be DNR.  R118's Admission indicated R118's d transient ischemic disease, acute and failure, peripheral infarction, hemiple pulmonary disease.  A review of R118's a POLST signed by was also signed by indicated R118's who are to be full Code.  A review of active record for R118 ind 4/8/18, for resuscit also listed on the trecord.  A review of the tearesuscitation statuplan indicated code aggressive measure.  On 8/22/18, at 10:2	ated conflicting resuscitation I Code.  m sheet indicated R4's code  Record printed 8/23/18, iagnoses included history of attack, atherosclerotic heart disubacute hepatic failure, heart vascular disease, cerebral gia, and chronic obstructive expaper medical record included y R188's wife (undated) which y a doctor on 5/7/15, and wish for resuscitation status to corders in the electronic health cluded an active order dated tation status of DNR. DNR was op page of the electronic health as the condition of the condition of the electronic health and sheet indicated R118's set to be CPR, and R118's care extens of CPR with	F 84	,		
	(DON) stated the t trained medication	e status.  1 p.m. the director of nursing eam sheet that the nurse or aide (TMA) has on the s each resident's codes status,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION  NG	-	` '	E SURVEY PLETED
		245366	B. WING		_	08/	23/2018
	PROVIDER OR SUPPLIER  ENSEN HEALTH & RE	EHABILITATION CENTER	•	STREET ADDRESS, CITY, STA 2501 RICE LAKE ROAD DULUTH, MN 55811	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD D TO THE APPROPR CIENCY)	BE	(X5) COMPLETION DATE
F 842 F 880 SS=D	room number and range and rangement based arrangement arrang	miscellaneous information. NA's carry with them do not t's code status. The DON anager verified the group ss. If there were changes to e nurse manager make et. The team sheet gets and/or upon admission.  PR dated 7/18, directed each egarding CPR or DNR code available for quick colicy lacked where staff code status information.  A Control 1)(2)(4)(e)(f)  Control stablish and maintain an and control program a safe, sanitary and ment and to help prevent the ransmission of communicable tions.  In prevention and control stablish an infection prevention on (IPCP) that must include, at owing elements:  Stem for preventing, identifying, ting, and controlling infections diseases for all residents, estors, and other individuals	F 8				10/2/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING		08	/23/2018	
	PROVIDER OR SUPPLIER ENSEN HEALTH & RI	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 880	procedures for the but are not limited to (i) A system of survive possible communication infections before the persons in the faciliation (ii) When and to whome which was to be followed to proceed (iii) Standard and the top be followed to proceed (iv) When and how resident; including (A) The type and down the involved, and (B) A requirement to least restrictive posticumstances.  (v) The circumstance with the contact with resident contact with resident contact will transmit (vi) The hand hygient by staff involved in \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must have communicated to the system of the survive survive system.	en standards, policies, and program, which must include, to: reillance designed to identify table diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ransmission-based precautions event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the esible for the resident under the ces under which the facility by es with a communicable skin lesions from direct ints or their food, if direct the disease; and the procedures to be followed direct resident contact.	F8	80			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY PLETED
		245366	B. WING		08/2	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	§483.80(f) Annual rather facility will condidered provided the same of the sam	review. duct an annual review of its heir program, as necessary. NT is not met as evidenced dion, interview, and document hailed to ensure proper hand hares for 2 of 4 residents (R4, howel and bladder.  The mum Data Set (MDS) dated had moderately impaired hoccasionally incontinent of halso indicated he required he with personal hygiene and  a.m. nursing assistant (NA)-0 hat offer breakfast and morning had gloves prior to assisting R4 had completed cares. Without had gloves, NA-O assisted R4 in hown, pulling up the comforter, hat ge, and adjusting the bed hot control. After that, NA-O hat room and removed his gloves,	F 880	F880  Infection Control "R4 and R128 are receiving cares include proper hand washing and guse.  "Other residents are receiving car include proper hand washing and guse.  "Nursing staff have been re-educate regarding facility expectation for proper hand washing and glove use, include hand sanitizing between glove chate.  "Observational check off regarding washing has been added to the orientation process for nursing state.  "Observational audits to monitor for compliance with hand washing and use expectations will be conducted nurse managers or designee two as weekly x4 weeks, then two audits of other week x2 weeks, then as dire QAPI.	es that glove ated roper ding nges. g hand ff. or d glove d by audits every	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245366	B. WING		08	/23/2018
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2501 RICE LAKE ROAD DULUTH, MN 55811	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	indicated R128 had dementia with behat R128's quarterly M R128 had severely sometimes able to sometimes able to further indicated R assistance with all including toileting, cares after any incompart of the dining room R128's care plan of had dementia with neurogenic bladde after any incontiner On 8/22/18, at 9:36 from the dining room R128 onto the toile wheelchair next to NA-N assisted R12 two hands, and usi R128 to standing, if the toilet. After R12 wiped R128's peripulling up her pant moved the wheelch handles, took off the removed the glove hygiene, NA-N flustransfer belt and pugarbage bag, place unlocked the wheel bathroom door har R128's wheelchair	d diagnoses that included aviors, and muscle weakness.  DS dated 8/8/18, indicted impaired cognition, was understand others and was be understood. R128's MDS 128 required extensive activities of daily living (ADLs), and staff were to provide periontinent episode.  ated 5/5/18, indicated R128 behaviors, history of a r, and to provide peri cares at episode.  S a.m. NA-N wheeled R128 m to her bedroom to assist t. NA-N locked R128's the toilet and put on gloves. 28 to hold the grab bars with ang a transfer belt, assisted then transferring and sitting on 28 urinated in the toilet, NA-N area and assisted R128 in s. With the soiled gloves, NA-N hair position by using the let transfer belt, and then s. Without performing hand hed the toilet, rolled up the let it in her pocket, drew up the let a new bag in the container, lichair brakes, and used the lidle to open the door and push into the hallway. When NA-N lity room, she entered and	F 8	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245366	B. WING			08/	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION CENTER		2501	EET ADDRESS, CITY, STATE, ZIP CODE I RICE LAKE ROAD LUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	On 8/22/18, at 9:45 realized she forgot had been taught to removal. NA-N also touching "dirty" iten until she was in the hands.  On 8/23/18, at 8:20 (LPN)-B stated the touched the patient their hands. LPN-B contact, no matter Hands should be wremoval, then staff clothing bed height On 8/23/18, at 12:2 (DON) stated she expressions.	is a.m. NA-N stated she to wash her hands, and she wash hands after glove o stated that she was still as so it made sense to wait soiled utility room to wash a.m. licensed practical nurse goal was if a staff person to the thickness of the staff have skin what, they wash their hands ashed or sanitized after glove can go back and adjust	F8	80			

F5366029

PRINTED: 09/25/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 01</b>		TE SURVEY MPLETED
		245366	B. WING		08	3/22/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RI	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 2501 RICE LAKE ROAD DULUTH, MN 55811	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI T <b>A</b> G	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	тѕ	K	00		
	FIRE SAFETY					
	ALLEGATION OF ODEPARTMENT'S A SIGNATURE AT THE	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.				
,	ONSITE REVISIT OF CONDUCTED TO SUBSTANTIAL COREGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT DMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION.	-			
	Minnesota Departr Fire Marshal Divisi Chris Jensen Heal was found not in correquirements for population of Medicard 483.70(a), Life Safedition of National	articipation in I at 42 CFR, Subpart Tety from Fire, and the 2012 Fire Protection Association I01, Life Safety Code (LSC),				
		SE AN EPOC, A PAPER COPY CORRECTION IS NOT		EPO		
	PLEASE RETURN CORRECTION FO	I THE PLAN OF OR THE FIRE SAFETY				

09/20/2018

**Electronically Signed** 

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.

Facility ID: 00598

PRINTED: 09/25/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						) DATE SURVEY COMPLETED	
		245366	B. WING	_		08/	22/2018
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD OULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUST FOLLOWING INFO  1. A description of to correct the defication of the correct the correct the defication of the correct the deficiency of the correct the	ractions Division eet, Suite 145 1 th: state.mn.us  DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. roposed, completion date. or title of the person rection and monitoring to rence of the deficiency.  Ith and Rehabilitation Center is with a partial basement. The tructed at 3 different times. The as constructed in 1967 and was of Type II(111) construction. In tition(s) was constructed to the determined to be of Type II. Because the original building meet the construction type g buildings, the facility was		000			

Event ID: 55P921

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY  IPLETED	
		245366	B. WING		08/	22/2018
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	complete automatic facility has a compl smoke detection in	sprinkler protected, by a c fire sprinkler system. The ete fire alarm system with the corridors and spaces r, that is monitored for	K 000			
	and had a census of survey.	censed capacity of 170 beds of 160 at the time of the 42 CFR, Subpart 483.70(a) is				
	components appro- accordance with NI and NFPA 72, National provide effective was building. In areas in detection is installe unit. In new occupant at notification applia and supervising sta	- Installation is installed with systems and wed for the purpose in FPA 70, National Electric Code anal Fire Alarm Code to arning of fire in any part of the ot continuously occupied, d at each fire alarm control ancy, detection is also installed ance circuit power extenders, ation transmitting equipment. wiring or other transmission d for integrity.	K 34			10/2/18
	This REQUIREMED by:	NT is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245366	B. WING	_		08/2	2/2018
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		25	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD ULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 341	facility failed to insist system in accordar 2012 NFPA 101, "19.3.4.1 and 9.6, a "National Fire Alars sections 29.8.3.4. adversely affect the system that could emergency actions affect 4 of 170 resigned in the accordance of the Administrators inches of a HVAC	intion and staff interview, the stall and maintain the fire alarmance with the requirements of The Life Safety Code" Sections is well as 2010 NFPA 72, in and Signaling Code" These deficient practices could be functioning of the fire alarmadelay the timely notification and is for the facility thus negatively idents, as well as an other of staff, and visitors ween 10:00 a.m. to 2:00 p.m. servation revealed, that the ocated in the corridor outside of office was installed within 36 went diffuser.	K3	341	The smoke detector was moved 3 away from the air vent. The correwas completed on 8/22/2018. The Environmental Services Director was responsible for the completion of the and is responsible for monitoring the prevent a reoccurrence of this defendance.	ction e vas he work o	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 10, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5366029

#### Dear Administrator:

The above facility was surveyed on August 20, 2018 through August 23, 2018 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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Chris Jensen Health & Rehabilitation Center September 10, 2018 Page 2

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 Teresa Ament, Unit Supervisor at (218) 302-6151 or teresa.ament@state.mn.us.

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

Licensing and Certification Program

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00598	B. WING		08/2	3/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	HABILITATION C 2501 RIC	DDRESS, CITY, SELAKE ROA, MN 55811	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf elicensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/20/18 **Electronically Signed** 

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/3	23/2018
NAME OF PRO	VIDER OR SUPPLIER	00000	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	00/2	.5/2010
CHRIS JENS	SEN HEALTH & RE	HABILITATION C		E LAKE ROA MN 55811	AD.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
De you is a en tex Sta coo coo Mil Or De the Ple co an Mil the fect as Nu Th coo sta "S' an coo fin aft ev are Tir PL FC "PL AF	u electronically. A necessary for State ter the word "correct. You must then ate licensure procompletion date, the rrected prior to el nnesota Department's staff verection that you I didentify the date in the state Licensing deral software. Tasigned to Minnes a signed to Minnes arsing Homes.  The assigned tag may be assigned to Minnes a signed to Minnes arsing Homes.  The assigned tag may be a signed to Minnes a signed to Minnes are in the statement, and replaces the "Torrection order. The dings which are in the statement, idence by." Follow the statement, idence by." Follow the Suggested I me period for Correct EASE DISREGA DURTH COLUMN ROVIDER'S PLA PPLIES TO FEDE	Althorders being subralthough no plan of cate Statutes/Rules, prected" in the box avaindicate in the electroless, under the header date your orders westronically submitting the first of Health.  Although no plan of the electroless, under the header date your orders westronically submitting the first of Health.  Although the above protection orders are issued our electronic plan of have reviewed these when they will be considered the first of Health is document of Health is document of Health is document of Deficiencies" of Comply" portion of the state of Deficiencies of Comply" portion of the state of This Rule is not meaning the surveyors fill Method of Correction	correction lease ailable for conic ling ill be ng to the sylvider and ed. or orders, completed. It cate the column the des the ce statute et as and of the ce statute et as and of the ce the c	2 000			

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/2	23/2018
	PROVIDER OR SUPPLIER	EHABILITATION C	2501 RICE	DRESS, CITY, SELAKE ROAM	STATE, ZIP CODE . <b>D</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2		2 000			
	PLAN OF CORREC	QUIREMENT TO SUI CTION FOR VIOLATI E STATUTES/RULE	ONS OF				
2 300	MN Rule 4658.0105 Competency			2 300			10/2/18
	are able to demons techniques necessa needs, as identified resident assessment comprehensive plant perform their assign		skills and nts' hensive the le to				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure licensed nursing staff demonstrated competency skills related to medication administration through a tube feeding for 1 of 2 residents (R148) reviewed for tube feeding.				corrected		
	Findings include:						
	dated 8/15/18, indic dysphagia (difficulty injury (TBI) and mu	Minimum Data Set (Meated diagnoses that assumed swallowing, traumatescle weakness. In ac R148 received tube f	included ic brain ldition,				
	R148 had an order tube feeding), 65 m hours continuously addition, a physicia R148 was to receiv	order dated 8/8/18, in for Jevity 1.0 (nutrition illiliter (ml) per/hour for from 8:00 a.m. to 5:0 n order dated 8/9/18, e 150 ml water flusho for four times daily for	on for for 21 00 a.m. In indicated es via				

Minnesota Department of Health

STATE FORM 6899 55P911 If continuation sheet 3 of 69

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BOILDING.			
		00598		B. WING		08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	EHABILITATION C		E LAKE ROA MN 55811	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 300	did not receive any received tube feedinursing was to admifree water flushes of follow facility tube follow facility follow facility follow facility follow facility fac	ated 8/16/18, indicate thing by mouth, and ing. The care plan inchinister the tube feed via g-tube, nursing water administered via g-tube. A a.m. registered nurse aring R148's medicate and ifferent medications of water. RN-D states of water. RN-D states of water. RN-D states arrived at R148's root obtained 200 ml of RN-D approached R	she dicated ing and as to bl, and be per  se (RN)-D utions. ons in ackets of quivalent ated she a g-tube. om, went i water in a 148, ag via and set	2 300			
	mixed in water, and medications crushe applying gloves, RI removed the tab clu with air into the fee stethoscope to che	d the rest of R148's ned in little plastic bage N-D was picked up thosure, and inserted a ding port as she liste ock for tube placemer	norning s. After ne g-tube, a syringe ned with a nt. RN-D				
	then separated the inserted the barrel administered 15 m poured the Potassi barrel and flushed clamped the g-tube water into the barrel	e, took the syringe off barrel and plunger. I into the g-tube port a I of water, clamped th um Chloride liquid in with 10 ml of water. I e and poured another el. RN-D emptied the into the water in the	RN-D ind ne g-tube, to the RN-D 10 ml of crushed				

Minnesota Department of Health

STATE FORM 6899 55P911 If continuation sheet 4 of 69

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00598	B. WING		08/2	3/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	HABII ITATION C	LAKE ROA	D		
		DULUTH,	MN 55811			I
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 300	Continued From pa	ge 4	2 300			
	and released it to a RN-D followed this RN-D repeated this crushed powdered mixing the medicati them into the barrel into the bathroom a water. RN-D returne flushed the tube. RI the crushed powderseparate occasions RN-D stated she hawater to complete the removed her gloves of water, cleansed without starting R14	dminsitered the medications. with a 10 ml flush of water. process of emptying the medications five times without ons with water before pouring. Once finished, RN-D went nd obtained another 200 ml of ed to R148's bed side, and N-D continued to administer red medications on two followed by water flushes. ad used a total of 350 ml of he water flushes. RN-D s, dumped the remaining 50 ml ner hands, and left the room 48's tube feeding.				
	orders and verified water flushes four thad given R148 more problem with medications are going to hold of medications settle." mixed the medications settle. The mixed the medications settle with them, because she her she would pour barrel with water 5 follow with a water from RN-D stated she diffeeding, and that with RN-D further stated starting the tube feed on 8/22/18, at 1:40 not demonstrated of medication administrated all the licens check list. RN-F starting to hold water for the medication administrated all the licens check list. RN-F starting the tube feed medication administrated all the licens check list. RN-F starting the tube feed medication administrated all the licens check list. RN-F starting the tube feed medication administrated all the licens check list. RN-F starting water flushed medication administrated water flushed medication administrated all the licens check list.	reviewed R148's physician R148 was to receive 150 ml of imes a day. RN-D stated she are water because she had a rations not draining, and she iff the tube feeding "To let the RN-D stated she had not ons prior to administering had asked RN-E, who told the powder into the syringe ml to 10 ml of water, and then flush of the same amount. In the dome the was going to hold off on eding.  p.m. RN-F verified RN-D had ompetency skills related to tration through a g-tube. RN-F ed nursing staff had a clinical sted both LPN's and RN's had quirements in the checklist.				

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STATEMENT OF DEFICIENCIES (X1)

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1` '			SURVEY LETED
				A. BUILDING:			
		00598		B. WING		08/2	3/2018
NAME OF F	PROVIDER OR SUPPLIER	\$	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	HARII ITATION C		E LAKE ROA MN 55811	.D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 300	Continued From pa	ge 5		2 300			
	The Director of Nur develop, review, an procedures to ensu The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance.	THOD OF CORRECTION: Twe	d d d es and d going				
2 575	MN Rule 4658.043 Management Service	0 Subp. 1 Health Infor ce	mation	2 575			10/2/18
	Subpart 1. Health information management. A nursing home must maintain health information management services, including clinical records, in accordance with accepted professional standards and practices, federal regulations, and state statutes pertaining to the content of the clinical record, health care data, computerization, confidentiality, retention, and retrieval. For purposes of this part, "health information management" means the collection, analysis, and dissemination of data to support decisions related to: disease prevention and resident care; effectiveness of care; reimbursement and payment; planning, research, and policy analysis; and regulations.						
	by: Based on interview facility failed to mail	ent is not met as evide and document review, ntain an accurate, and ecord related to resuso	, the		corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	FHARII ITATION C		E LAKE ROA MN 55811	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 575	Continued From pa	age 6		2 575			
	status for 3 of 36 re reviewed for advan	esidents (R72, R4, R1 ced directives.	18)				
	Findings include:						
	indicated R72's dia	ecord printed 8/23/18 gnoses included Alzhe hypertension, and typ	eimer's				
	severely cognitively	ted 7/27/17, indicated y impaired, and was al ls, with confusion incre	ble to				
	Orders for Life Sus	al record included a P staining Treatment (PC gned by R72, which dir esuscitation (CPR).	DLST)				
	page indicated DNI	edical record, R72's p R (Do Not Resuscitate rs, dated 4/9/18, indica	e), and				
	R4's diagnoses inc	cord printed 8/23/18, i luded dementia, Alzhe ney failure and chronic ary disease.	eimer's				
		mum Data Set (MDS) 4 was cognitively impa					
	POLST dated 7/30	aper medical record in /18, and signed by a n indicating R4's wish fo s to be DNR.	urse				
		orders in the electronic ded an active order da					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/23/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
CHRIS J	ENSEN HEALTH & RE	-HABII ITATION C	E LAKE ROA MN 55811	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 575	Continued From pa	ge 7	2 575			
	4/8/18, for Full Cod 7/30/18, for DNR.	e, and an active order dated				
		of the page of R4's electronic ated conflicting resuscitation Code.				
	A review of the tear status to be DNR.	m sheet indicated R4's code				
	R118's Admission Record printed 8/23/18, indicated R118's diagnoses included history of transient ischemic attack, atherosclerotic heart disease, acute and subacute hepatic failure, heart failure, peripheral vascular disease, cerebral infarction, hemiplegia, and chronic obstructive pulmonary disease.					
	a POLST signed by was also signed by	paper medical record included 7R188's wife (undated) which a doctor on 5/7/15, and sh for resuscitation status to				
	record for R118 inc 4/8/18, for resuscita	orders in the electronic health luded an active order dated ation status of DNR. DNR was up page of the electronic health				
	resuscitation status	m sheet indicated R118's to be CPR, and R118's care status of CPR with es.				
		8 a.m. R118's wife, Family nfirmed that they wanted R118 status.				
	On 8/21/18, at 3:31	p.m. the director of nursing				

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STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		00598	B. WING		08/2	3/2018
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, \$ <b>E LAKE RO</b> #	STATE, ZIP CODE		
CHRIS JI	ENSEN HEALTH & RI	EHARII ITATION C	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 575	trained medication medication cart has room number and range include the resident stated the nurse may sheet for correctnethe code status, the changes to the she updated as needed. The facility policy Cresident's choice restatus was readily a identification. The procedures the code status was readily a identification. The procedure of Nurdevelop, review, an procedures to ensure cord is correct. The Director of Nurdevelop monitoring compliance.	eam sheet that the nurse or aide (TMA) has on the seach resident's codes status, miscellaneous information.  NA's carry with them do not t's code status. The DON anager verified the group ss. If there were changes to enurse manager make et. The team sheet gets and/or upon admission.  EPR dated 7/18, directed each egarding CPR or DNR code	2 575			
2 800	Staffing requirement	0 Subp. 1 Nursing Personnel; nts requirements. A nursing	2 800			10/2/18
		n duty at all times a sufficient				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/	23/2018
	PROVIDER OR SUPPLIER  ENSEN HEALTH & RE	EHABILITATION C	2501 RICE	DRESS, CITY, E E LAKE ROA MN 55811	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 800	number of qualified registered nurses, I nursing assistants t residents at all nurs in all buildings if mo involved. This inclu and vacation replace	I nursing personnel, icensed practical nut to meet the needs of ses' stations, on all floore than one building udes relief duty, wee the cements.	trses, and the pors, and is kends,	2 800			
	by: Based on observation review, the facility for to provide care for the facility for the	ent is not met as evi ion, interview, and do ailed to ensure adeq residents on the Ced tial to affect all 40 res	ocument uate staff ar Unit.		corrected		
	On 8/20/18, at 4:54 Cedar dining room not finish serving th evening meal was s R35's 14 day Minim	p.m. the food arriver for the evening meal ne the meal until 6:15 scheduled for 5:25 p. num Data Set (MDS)	. Staff did p.m. The m. dated				
	impaired, and requi and toileting.  During interview on stated he had a cha in the morning. He bed, and sometime	ne was moderately coired assistance for train 8/20/18, at 6:28 p.m. allenge getting up for stated he did not like as the facility was uncakfast. He stated this	n. R35 breakfast eating in derstaffed				
	indicated R35's call a.m. and was not a	e activity report dated l light was on 8/18/18 nswered until 8:32 a inutes. On 8/19/18, F	3, at 7:14 .m. a total				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/	23/2018
	PROVIDER OR SUPPLIER	EHABILITATION C	2501 RICE	DRESS, CITY, S E LAKE ROA MN 55811	TATE, ZIP CODE <b>D</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 800	answered until 7:39 and 11 seconds.  R69's quarterly MD had intact cognition assitance with all accounts.  During an interview p.m. family membe facility a lot. FM-B slong time to be ansit went for up to 25 answered. R69 state to the bathroom in I R95's annual MDS was severely cognitiving. The MDS fur important to R95 the his favorite activitie 7/26/18, identified of disturbance, and dimet his needs, offer and reorient as need identified behaviors frustrated, especial staff did not respondence for hunger, the dining room. At the nurses station of brother. Licensed preserved the his need preserved the dining room. At the nurses station of brother. Licensed preserved the his need preserved the dining room. At the nurses station of brother. Licensed preserved the his needs of the nurses station of brother. Licensed preserved the his needs of the nurses station of the his needs of the nurses station of the nurses s	at 7:05 a.m. and not a.m. a total of 34 m. S dated 6/14/18, ind , and required extenctivities of daily living with R69 on 8/20/18 r (FM)-B stated she stated R69's call light wered, and stated sominutes without beinged he almost always	inutes icated he sive J. S, at 1:59 was at the took a cometimes g shad to go ated he required f daily very rticipate in ated coral coate and daily care further of hear, or ed staff to needs. D5 a.m. g around n front of all his - B told I find the cropelling per pushed	2 800			

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Minneso	<u>ota Department of He</u>	ealth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMPL	_ETED
		00598	B. WING		08/2	3/2018
					1 00/2	5/2010
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
CHDIS I	ENSEN HEALTH & RE	EHARILITATION C 2501 RIC	E LAKE ROA	AD .		
CHRISTI	ENSEN HEALIH & KE	DULUTH	I, MN 55811			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				2,		
2 800	Continued From pa	age 11	2 800			
	was on turned to a	a talk show. At 7:39 a.m. R95				,
		ng himself in the dining room.				
		ittempted to exit the unit via an				
ļ		Registered nurse (RN)-B				
ļ		him he needed his hearing				
ļ		RN-B who she was and called				
ļ		50 a.m. R95 was again				
		ble in the dining room by a staf	·f			
		not offered anything to eat or	•			
ļ		othing on the table except a				
		box of tissues. R95 began				
		of tissues onto the table At 8:05				
		himself away from the dining				
		time, a radio was playing tune	4			
		n, three other men were sitting				
		one was talking. Three other				
ļ		ing in the dining room with their	-			
		rth resident was sitting in a				
ļ		er hands covering her face and				
		at alone at a table with her				
		ont of her. There was no				
ļ		engage R95 or the other				
		e observation. At 8:18 a.m.				
		attempt to exit the unit through	n			
		Staff again intervened and did				
		ave. R95 pushed the elevator				
		staff member brought him				
		the dining room and walked				
ļ		R95 propelled away from the				
ļ		pack to the elevator. At 8:25				
ļ	a.m. the elevator do	oor opened and R95				
ļ	attempted to exit bu	ut his wheel chair was stuck or	۱			
	the wall preventing	him from moving. At 8:27 a.m	.			
ļ		pened again and R95 again				
ļ	attempted to get in.	. A staff member brought him				
	back to the table in	the dining room. At 8:33 a.m.				1
		n on the floor. A resident				1
		picked up the napkin and gave	е			ı
		w the napkin under the table a				1
		ttempted to stand up out of the				1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/	23/2018
	PROVIDER OR SUPPLIER	HABILITATION C 2501 RICI	DRESS, CITY, S E LAKE ROA MN 55811	TATE, ZIP CODE D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 800	wheel chair to pick attempted to get outhe napkin. While the fell onto his right side. On 8/22/18, at 9:13 breakfast meal on the scheduled to begin R11's annual MDS was cognitively into assistance for bed transfers. The MDS always continent of the compact of th	it up. At 8:36 a.m. R95 It of his wheel chair to pick up rying to kneel on the floor, R95 Ide on the floor.  a.m. staff began serving the the unit. The meal was at 8:00 a.m.  dated 5/23/18, indicated he loct, and required extensive mobility, toileting, and further indicated R11 was bowel and bladder.  p.m. R11's family member visited the facility daily. FM-C le to LPN-B several times system. She stated R11 knew lith stayed on, and stated she lis quality of life when he had athroom. FM-C stated staff bathroom, and said they le call light, but would not leted if R11 had to wait too long le answered he would bang on FM-C stated it was a she got to the facility and old her R11 was banging on	2 800	DEFICIENCY)		
	LPN-B not to assign	ner stated she had asked in the new staff to R11, if up having to train them in not my job."				
	was moderately con extensive assitance mobility, transfers,	dated 6/20/18, indicated he gnitively impaired, required e from two staff for bed and toileting. The MDS also always incontinent of bowel				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	FHARII ITATION C	E LAKE ROA MN 55811	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPLICATION OF THE APPLICAT	OULD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ige 13	2 800			
	(FM-D) stated she when she was not a R48's face was new never brushed. FM at the facility to find lying in a urine soal stated the weekend another day she had urine comforter. FM-D stated specific staff mer LPN-B several time stated she felt like to lack of competent so one was overseeing	ip.m. R48's family member did not feel her R48 was safe at the facility. FM-D stated ver washed, and his teeth were -D stated one day she arrived R48 hanging out of bed and ked incontinence brief. FM-D ds were "horrible," and stated id come to the facility, and e soaked sheets under the ated she had concerns about inber, and had spoken to es about her concerns. FM-D there was a lack of staff, and a staff on the unit, and stated no g the staff on the unit. FM-D were not enough staff to get leal in time.				
	there were five NA' morning, there were stated she was the morning and stated LPN-C stated the fa	a.m. LPN-C stated although s working on the unit that e usually only four. LPN-C also third nurse on the unit that I that also wasn't typical. acility did not schedule staff by It's hard, I almost never get a				
	usually four NA's so nurses. RN-B state breakfast at 9:00 a there were several	p.m. RN-B stated there were cheduled on the unit and two d it was typical to serve .m. RN-B stated although additional staff in the dining were not usually there.				
	staffed based on ce had 40 residents th	p.m. LPN-B stated the facility ensus. He stated when the unit e facility would schedule an our hours. LPN-B stated if the				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/2	3/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
CHRIS J	ENSEN HEALTH & RE	HABII ITATION C	E LAKE ROA MN 55811	.D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	scheduled. LPN-B sthe staffing levels if stated he had receir related to long call I from a few resident staff felt like they not the longer call light meal times.  A review of facility of following:  5/8/18, R11 reported He reported call light and reported being minutes. FM-C stat received care when after his needs. The spoke with staff and important, and they prevent long call light facility would like. Spoke with staff on indicated facility wo with better options to wait 45 minutes, did not come at all. performed and ider minutes on 7/31/18	39 there were four NA's stated there was no change in acuity increased. LPN-B ved complaints from families light wait times, had concerns s, and had heard in general, eeded more help. He stated times were generally around. Grievance Forms identified the dhe had a "rough few days." In the wait times of 30 minutes left on the toilet for 30 ed she felt like R11 only a she was in the facility to look ereport indicated LPN-B dexplained the call lights were reded to work as a team to hit wait times.  In the toilet for 30 ed she felt lights were reded to work as a team to hit wait times.  In the call lights took too long to report indicated a call light did, and R150 had a legitimate the swere on longer than the light report indicated LPN-B importance of call lights, and all work with staff to come up to meet resident needs.  In the call light was not being to meet resident needs.  In the call light was not being to meet resident needs.  In the call light was not being to meet resident needs.	2 800			

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AND DIAM OF CODDECTION INDESTRUCTION AND DESCRIPTION AND DESCR		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00598	B. WING		08/2	3/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CUDIC I	ENCENTIENTILO DI	ZUARU ITATION C 2501 RICI	E LAKE ROA	VD		
CHKIS J	ENSEN HEALTH & RI	DULUTH,	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ige 15	2 800			
	they are too busy to form labeled Grieva stated she did not r stated it could have she had recently m	o help her. A section of the ance Resolution indicated R77 remember saying this, and been from another unit as oved. The grievance form a not confirmed and no action				
		8/23/18, at 10:29 a.m. R77 nber saying that, it tends to be				
	recalled a concern FM-C. LPN-B state staff member didn't was a lack of consi stated when a fami concern he would tright away if he couthe employee, but we state to the employee.	p.m. LPN-B stated he about a staff member from d the concern was that the know R11 well, and felt there stency in staffing. LPN-B ly member came to him with a ry to address it and correct it lid. He stated he would talk to would not necessarily ersation. LPN-B did not recall the NA by FM-D.				
	director (HRD) and were interviewed. I morning to discuss and acuity changes expressed concern encouraged them to team lead. The DO were responsible for concerns by reside DON stated concernaudited to ensure for meals running late meals were running are still getting peo	p.m. the human resources the director of nursing (DON) The HRD stated staff met every census, potential admissions, at The HRD stated if staff is related to staffing levels, she of go to the nurse manager or N stated the nurse managers or following up on staffing ints, families and staff. The ins were documented and follow up. In regard to the on the units, the DON stated grate on units because NA's ple up. She stated she was little late, but did not realize it				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING	A. BUILDING:		
		00598	B. WING		08/2	23/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
CHRIS JI	ENSEN HEALTH & RI	FHABII ITATION C	CE LAKE ROA I, MN 55811	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	The Director of Nur develop, review, an procedures to ensure each unit to ensure The Director of Nur educate all appropri procedures. The Director of Nur develop monitoring compliance.	_				
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from the resident must remain prefers to remain in This MN Requirem by:  Based on observations.	a general. A resident must re and treatment, personal and supervision based on and preferences as identified in eresident assessment and scribed in parts 4658.0400 and sing home resident must be outpossible unless there is a the attending physician that the ain in bed or the resident in bed.	d t	corrected		10/2/18
	Based on observat	tion, interview, and document failed to implement identified		corrected		

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AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/	23/2018
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	HABII ITATION C	RICE LAKE ROA	<b>/</b> D		
	I	DULU	JTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17	2 830			
	interventions to red residents (R95, R13 to conduct ongoing of falls to determine	uce the risk for falls for 2 or 3). In addition, the facility fa comprehensive assessme causal factors to reduce to 6 residents (R95, R147, R	iled nt ne			
	Findings include:					
	7/25/18, indicated of dementia, Parkinso MDS also indicated impaired, required activities of daily livincontinent of bowe identified a risk for the demands of the demands	num Data Set (MDS) dated liagnoses that included n's disease and diabetes. R95 was severely cognitivextensive assistance for alling (ADLs) and was frequel and bladder. R95's care pfalls related to confusion are and indicated R95 was needs.	ely ntly lan			
	7:05 a.m. until 8:33 observed sitting in haround the dining refront of the nurse's his brother. License R95 to give him a linumber for him. R9 fading yellow bruise propelling himself dinember pushed him where a television was propelling himsa.m. R95 attempted elevator door, regis and told R95 he neasked RN-B who share R95 was again escedining room by a statement of the second statement o	as continuously observed from a.m. At 7:05 a.m. R95 was as wheelchair, self-propelling oom. At 7:12 a.m. R95 was station desk requesting to be practical nurse (LPN)-Bottle bit, and he would find the foliation of the first own the hallway. A staff on back into the dining room was on to a talk show. R95 stelf in the dining room. At 7 to exit the unit via an operatered nurse (RN)-B interveleded his hearing aids. R95 ne was and called her a nail orted back to a table in the laff member, but was not eat or drink. A linen napkin	ng in call old ie ed ed i, :46 in			

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Minneso	<u>ita Department of He</u>	ealth					
		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED
		00598		B. WING		00/2	2/2040
		00598				00/2	3/2018
NAME OF F	PROVIDER OR SUPPLIER	STRE	EET ADD	DRESS, CITY, S	STATE, ZIP CODE		
		250 <sup>,</sup>	1 RICE	LAKE ROA	.D		
CHRIS J	ENSEN HEALTH & RE	EHABILITATION C DUL	UTH,	MN 55811			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
					DEFICIENCY)		
2 830	Continued From pa	age 18		2 830			
	and a how of tissue	s were on the table. R95					
		e box of tissues onto the ta	ahla				
	. , ,	himself away from the dir					
		time, a radio was playing a					
		d three other men were sit					
		one was talking. Three ot					
		ng in the dining room with					
		th resident was sitting in a					
		er hands covering her face					
		at alone at a table with her					
	arms crossed in fro	ont of her. There was no					
	attempt by staff to e	engage R95 or the other					
		e observation. At 8:18 a.m	١.				
	R95 made another	attempt to exit the unit thr	ough				
	the elevator door. S	Staff again intervened, and	d did				
	not allow him to lea	ive. R95 pushed the eleva	itor				
		a staff member brought hin					
		the dining room and walke					
		ed away from the table and					
		e elevator. At 8:25 a.m. the					
		ed, and R95 attempted to	exit				
		was stuck on the wall					
		n moving. At 8:27 a.m. the	•				
		ed again, and R95 again	aina				
		. A staff member brought h					
		the dining room. At 8:33 an on the floor. A resident	a.III.				
		picked up the napkin and	aven				
		w the napkin under the tab					
		ttempted to stand up out o					
		it up. While trying to kneel					
		nto his right side on the flo					
	T	to the fall and stated to R9					
		rpose didn't you?" LPN -C					
		taff member, "He so did th					
		C then turned to R95 and					
		hy he put himself on the flo	oor.				
		g on the floor. LPN-C state					
	R95, "You threw yo	ourself on the floor, why did	d you				
	do that?" At this tim	ne, R95 remained on the fl	loor				

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AND DIAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00598	B. WING		08/	23/2018
	PROVIDER OR SUPPLIER  ENSEN HEALTH & RE	FHABILITATION C 2501 F	r address, city, s RICE LAKE ROA TH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	with five staff membridisplayed signs of a staff and squeezed with the other hand certified nurse prace R95 was lying, and stated R95 put him had been wild all ni to punch staff. Duri no attempts by staff toileting or any staff. A review of facility of following:  A Resident Incident indicated R95 was stood up and slid to R95 had numerous issues. An interdisc Cause Review date program to help wit initiated, and R95 was with his arm and ell pressure pad alarm extensive fall histor judgement. An IDT	bers standing over him. R95 agitation. R95 attempted to he LPN-C's hand, pointed at he and stated, "It was you." The stitioner walked over to where asked what happened. LPN self on the floor, and stated ght, throwing things and trying the observation there we for activity engagement.  It Report dated 7/30/18, holding onto a fire door bar, on the floor. The report indicate at Balls, and had impulse control was was to be moved closer to the near room became available.  It Report dated 7/31/18, found sitting on his fall mat bow still on the bed on the near report indicated an any, impulse control, and poor Root Cause Review dated onsider walking program to see the seed on	nit er ie e l-C he ng re  ted rol g			
	indicated R95 was on his buttocks and against the bed. Th was placed, and ind	t Report dated 8/3/18, found on the floor mat sitting I leaning on his left side le report indicated a tabs ala dicated R95 had a history of s. An IDT Root Cause Revie	ırm			

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AND DIAN OF CORRECTION TO TRENTIFICATION NUMBERS		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/	23/2018
	PROVIDER OR SUPPLIER	HABILITATION C 2501	ET ADDRESS, CITY, RICE LAKE ROA UTH, MN 55811	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO I DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	indicated R95's preand replaced with a A Resident Incident indicated R95 was wheelchair, and an assist, causing R95 Review dated 8/10/therapy to screen for a need for new anti A progress note dawas witnessed putth his wheel chair.  A Falls Risk Post - 8/14/18, indicated Fand sustained a fall dated 8/14/18, indicated Fand sustained a fall dated 8/14/18, indicated Fand sustained and discurseroquel.  A progress note dawas wide awake, who wide aw	ssure alarm was removed tab alarm.  Report dated 8/8/18, attempting to sit up from hother resident attempted to to fall. An IDT Root Caus 18, indicated occupation or wheelchair positioning, a-rollbacks for wheel chair.  Ited 8/11/18, indicated R95 ing himself on the floor best atted the facility was currently as at the nurse's state. An IDT Root Cause Reviewated the facility was currently as a	is o e and side ion ew ntly			

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		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00598	B. WING		08/2	3/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	FHABILITATION C	E LAKE ROA	ND .		
		DULUTH,	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 21	2 830			
	rolling himself arou	nd on the floor.				
	indicated R95 fell w in his wheelchair w correlating progres R95 was propelling	t Report dated 8/22/18, while sitting in the dining room ith his tabs alarm on. A s note dated 8/22/18, indicated himself all over the dining self on the floor to "get				
	stated R95 would p stated staff keep hi because he will "po the floor. NA-B stat comprehended wha stated R95 could u stated if staff asked sometimes tell ther by the nurse's station	o a.m. nursing assistant (NA)-B out himself on the floor and m by the nurses station op" himself out of bed and onto eed she did not know if R95 at staff were saying or not, but nderstand simple cues. NA-B d R95 what he wanted he could m. NA-B stated staff put R95 on, but he got mad when staff that would lead to behaviors.				
	couple of times she himself out of his c roll out of bed. LPN in jail at the facility,	5 a.m. LPN-D stated the last e worked R95 tried to push hair. LPN-D stated R95 would I-D stated R95 thought he was and did not understand he LPN-D stated R95 would say attention to him.				
	fall occurs, the nurs term intervention, the information and revenues. LPN-B stated meeting, and the te working on other up and initiated or chall stated R95 had a second	33 a.m. LPN-B stated after a se will come up with a short hen he would review the view what was done in the falls were discussed in an IDT eam discussed what was nits, discussed interventions, nged interventions. LPN-B ignificant history of falls, and us interventions in place.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` ′	E CONSTRUCTION		SURVEY PLETED
				B WINC			
		00598		B. WING		08/	23/2018
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	EHABILITATION C		E LAKE ROA MN 55811	.D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 22		2 830			
	family member (FM has laid in bed for hup. FM-A stated fal pay attention.  During a subseque p.m. R95's falls we LPN-B stated the ir continue with the continue with the continue with the continue with the falls LPN-B stated there indicate whether or implemented as an attempted by staff, were doing it. LPN-therapy assessmer 8/14/18, (in which a attempting to assist need for new anti-regards to the 8/14 indicated the provided Seroquel, LPN-B stant been adjusted in the state of the st	on 8/23/18, at 11:01 f)-A stated R95 told hours and no one wo ling was how R95 go nt interview on 8/23/2 re reviewed with LPN netervention on 7/24/15 urrent intervention of on 7/30/18, and 7/31 was no documentate not the walking programmer interventions was be and he did not know B stated the occupation initiated following the another resident was tangle R95 to stand) was collbacks for the wheely 18, intervention which der was to review R95 tated the Seroquel or until 8/22/18, and was R95 admitted to hos	nim he uld show to them to them to them to last at 2:02 l-B. s, was to an alarm. /18, fron to rameing if they ional he fall on the chair. In the chairs der had selected to a selected t				
	diagnoses that including the MDS further id cognitively impaired	dated 5/24/18, indicauded dementia, and olentified R13 was sevel, required extensive Ls, and was frequental and bladder.	diabetes. erely				
	falls related to dem incontinence, and the care plan direction bed, keep the be	ted 5/24/18, identified entia, bowel and blace behaviors with impulse cted staff to use gripped at a seated height, ated. The care plan a	lder iveness. er socks and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						E SURVEY PLETED	
		00598		B. WING		08/	23/2018
	PROVIDER OR SUPPLIER	EHABILITATION C	2501 RICE	DRESS, CITY, SELAKE ROAMN 55811	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	get up on overnight mattress at bed sid indicated staff to as identify a frequency.  On 8/22/18, at 7:51 sitting in her wheeld brakes on her wheeld brakes on her wheeld brakes on facility do following falls:  A Resident Incident indicated R13 was adoorway of her room history of falls. An III 5/21/18, indicated sup after nap during.  A Resident Incident indicated R13 was abed. An IDT Root Cindicated R13 was an indicated R13 wa	f a scoop mattress, of last rounds, and ante. Further, the care posist with toileting, but a.m. R13 was obserbair. R13 had auto be chair. R13 had auto be chair, and was proport the halls on the unit ocuments identified to the country of the report indicated the case of the country of the report indicated the case of the report indicated the case of the report of the report of the case of the report of the	ti-skid blan t did not rved ocking belling it. he l8, the ed a iew dated get R13 s, to her 6/6/18, up at 7:00 l8, her bed v dated R13 at er up. s, bed and the floor. , indicated	2 830			

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	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		) DATE SURVEY COMPLETED	
		00598		B. WING		08/	23/2018	
	PROVIDER OR SUPPLIER JENSEN HEALTH & RE	EHABILITATION C	2501 RICE	DRESS, CITY, SELAKE ROAMN 55811	STATE, ZIP CODE <b>D</b>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
2 830	A Resident Incident indicated R13 was supporting herself value Cause Review date sleep study was to On 8/23/18, at 1:27 study was initiated pattern for R13 how completed by staff. had been no follow determine if R13 was shift or not.  On 8/23/18, at 2:56 (DON) stated the ID discuss falls. The Date time of day the resident was hungruse the bathroom. discussed effective if changes were nenurse manager was on fall interventions.  R147's Admission Fidentified R147's didifficulty in walking, R147's Admission Fidentified R147's admission Fidentified R147's ADLs care processed admission.  R147's ADLs care processed admission.  R147 required exte with a walker for an admission.	Report dated 8/11/18 found sitting next to he with one arm. An IDT of 8/13/18, indicated a be implemented.  p.m. LPN-B stated a con 8/13/18, to determine the stated and sever, the sleep study LPN-B further stated and the stated are getting up on the or p.m. the director of not met every Monday pon stated the IDT diffalls occurred, whether y, thirsty or if they need the the stated on the DON stated the transs of the intervention of the pon stated of the pon stated the transs of the intervention of the pon stated the transs of the pon stated of the	sleep ine a was not there to vernight wirsing to scussed er the eded to eam also ons, and d the wing up  8, mentia, d falls. dicated d y ive assist R147 ut no falls icated -2 staff ten note	2 830				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE S COMPL	
	00598	B. WING		08/23	3/2018
NAME OF PROVIDER OR SUPPL	ER STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	2501 RIC	E LAKE ROA	ND.		
CHRIS JENSEN HEALTH 8	REHABILITATION C DULUTH,	MN 55811			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
R147 was indeptoilet upon rising and as needed. toilet R147 ever hand written not offer rest period 8/6/18, hand wrilay down after luindicated no am 1-2, stand pivot R147's Safety/F directed use of a access, check for etc., ensure enview facility procall light to requilocked placeme indicated nonski added. On 2/7/1 down after lunch resident frequer periods. On 3/6/to redirect to sit allows, offer resident written not wedge between tolerated. On 8/6 indicated a pad Review of the R the following fall On 1/26/18, at 1 hands and kneet her room. Had be at 11:00 p.m. Stareas noted, no Very pleasant ar conversation pe	8, hand written note indicated endent on the unit, and was to before and after meals, bedtime Staff were directed to offer to four hours on the night shift. A endeted 6/8/18, directed staff to with fluids and snacks. An ten note directed staff to offer to ench. An 8/9/18, hand written note coulation, transfer with assist of exeight bearing as tolerated. Alls care plan dated 1/8/12, wheelchair, call light in easy or unmet toileting needs, pain, aronment is free from clutter, fall botocol, reinforce need to use the east assistance, and secure or eat. On 1/30/18, hand written note of footwear (gripper socks) were 13, a note directed to offer to lay and the encouplinant with offered rest 18, a hand written note indicated down in dining room as resident period with sweets. On 8/6/18, a encouplinate indicated place abduction resident's legs at meal times as 1/18, a hand written note indicated alarm to wheelchair.	2 830			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00598	B. WING		08/2	3/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			E LAKE ROA			
CHRIS J	ENSEN HEALTH & RE	HABII ITATION C	MN 55811			
()(4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 26	2 830			
2 830	Assisted to toileting On 1/27/18, at 6:13 fall at 5:40 p.m. in hunsteady and agitat assist in any way. Knife. Resident fell allow any assistance Resident immediate began walking agai out of resident's har from area by staff. Notify of fall and agi On 1/29/18, at 3:33 witnessed fall on a. p.m., she was walk her back landing intwheelchair. She the done, was having a up off the floor with refused help. Sat in moved into one of the been sitting there. A was saying aggress other residents. No Tylenol at approximate to monitor for injury time.  On 2/25/18, at 11:5 on buttocks on the the back against the tray table was locat left of the resident. the resident stated, table and I sat down unwitnessed, neuro and remained at rescomplain of a slight	p.m. Resident had witnessed hallway. Resident walking ted. Would not allow staff to desident angry and carrying a conto left side and would not e or vitals to be taken. Bely stood up on own and n; did not hit head. Knife fell and and was quickly removed Writer spoke with husband to				
	went away within 5	minutes, resident stating, "I s this morning." Resident				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (INC.) PROVIDERS UPPLIERCUA IDENTIFICATION NUMBER:  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD DULUTH, MN 55811  SUMMARY STATEMENT OF DEFICIENCIES PRIETRY (REGULATORY OR LSC IDENTIFYING INFORMATION)  2830 Continued From page 27  moves all extremities without any pain or guarding. No injuries noted. Care plan followed, nonskid footwear on, resident last toileted at 9920, voiled and was continent, Just prior to fall resident was seen standing against wall in dining room conversing with other residents. Resident has history of falls very similar to this in nature. Placed another chair in the row of chairs where resident was standing so no room in between chairs to stand against wall, also made sign in large print with residents flast and and a picture of a chair, positioned right above a chair in that row and so it can also be seen when resident is pacing the hallway. Residents husband updated and is in agreement that it is worth a try. It is also noted that resident shared on Rispendone 0.25 milligrams (mg) mg twice a day on 1/2/4/18. Then Risperidone was increased to 0.5 mg twice a day and resident had falls on a marked decrease in violent outbursts, decrease in behaviors, starting to experience a stabilization of mood. This was in brief discussed with husband, none as causation, but observation and as data collection to give to MD-A (Psychiatrist) and PCP (primary care provider). Resident noted by writer to be compliant with all vital and neurological assessments, and to have a pleasant and calm affect. After fall, resident noted by writer to be compliant with all vital and neurological assessments, as to have a pleasant and calm affect. After fall, resident noted by writer to be compliant with all vital and neurological assessments, and to have a pleasant and calm affect. After fall, resident noted by writer to be compliant with all vital and neurological assessments.	winneso	ta Department of He	eaitri					
NAME OF PROVIDER OR SUPPLIER  CHRIS JENSEN HEALTH & REHABILITATION C  CHRIS JENSEN HEALTH & REHABILITATION C  SUMMARY STATEMENT OF DEFICIENCIES  GEACH DEFICIENCY MUST BE PRECEDED BY PULL  REQULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX  TAG  Continued From page 27  moves all extremities without any pain or  guarding. No injuries noted. Care plan followed,  nonskid footwear on, resident last toleted at  0920, voided and was continent. Just prior to fall  resident was seen standing against wall in dining  room conversing with other residents. Resident  has history of falls very similar to this in nature.  Placed another chair in the row of chairs where  resident was standing so no room in between  chairs to stand against wall, also made sign in  large print with resident's first name and, 'Sit  Here,' with a downward pointing arrow and a  picture of a chair, positioned right above a chair in that row ands os it can also be seen when resident  is pacing the hallway. Residents husband  updated and is in agreement that it it is worth a try.  It is also noted that resident started on  Risperdone 0.25 milligrams (mg) mg) wice a day  on 1/24/18. Then Risperidone was increased to  0.5 mg twice a day and resident had falls on  2/5/18, 2/10/18, and today, it is also noted that  resident had falls prior to the start of Risperidone,  resident had an arked decrease in violent  outbursts, decrease in behaviors, starting to  experience a stabilization of mood. This was in  brief discussed with husband, none as causation,  but observation and as data collection to give to  MD-A [Psychiatrist] and PCP [primary care  provider]. Resident noted by writer to be  compliant with all vital and neurological  assessments, and to have a pleasant and calm  affect. After fall, resident noted to play balloon  toss with activities, using all extremities without  pain.  On 3/20/18, at 9:08 p.m. At approximately 4:40  p.m. resident was walking down east hallway and					(X2) MULTIPL	E CONSTRUCTION		
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was pushed by another resident into the wall								
hitting her head and falling to the floor. Observed								

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
	00598	B. WING		08/2	3/2018
NAME OF PROVIDER OR SUPPLIEF	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OUDIO JENOEN LIEALTIL O F	2501 RICI	E LAKE ROA	VD		
CHRIS JENSEN HEALTH & R	DULUTH,	MN 55811			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
resident "was not writer responded i was heard from in lying on her right se responsive to staff resident. 5 x 5 cer on the right side of injuries observed. Policy. Some initiat noticed, but 15 mit baseline. Resident times, and walked pack was applied Denies any pain. For commands and at of nursing, RN [reson-call provider are new orders. Will consymptoms of concluster observed to a socializing with state appropriately. On 4/22/18, at 2:2 in dining area and from another resident. Resident of witnessed fall. Writing and the incident. Faxed rounding book. Net to observe. On 4/2 antipsychotic med see if it was causiful that occurred it nonskid footwear, conditions: psychic	age 28  ted that she noticed that responsive for a minute." This mmediately as a large noise cident. Resident was found ide in the hallway, but was when this writer approached timeter (cm) bump observed fresident head. No other Neuro checks started per I mild weakness in extremities nutes later resumed to assisted up off the floor two down to the dining room. Ice to resident head for 20 minutes. Resident able to follow a good dinner. DON [director gistered nurse] manager, and family notified of incident. No continue to monitor for signs and cussion or injury. Resident was walking around the unit aff and other resident  O p.m. Patient was ambulating fell backwards due to a push lent. No apparent injury and didn't hit her head, this was a ster spoke to Chris Jensen and patient's husband in regards incident report left in Doctors around status intact-will continue to maj/contributing to falls.  I.m. Falls Risk Post Fall ated the following. R147 had a mend lounge room. Wearing underlying diseases or atric or cognitive conditions, thritis, seizures. Takes	2 830			

Minnesota Department of Health

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Minnesota Department of Health

AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00598	B. WING		08/23/2018	
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	2501 RICE	LAKE ROA	D		
CHRIS JENSEN HEALTH & REHAE	DULUTH,	MN 55811			
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2 830 Continued From page 2	29	2 830			
psychotropic, anti-seizur unsteady at times, recei incontinence of bladder, Dementia. Was pushed On 5/8/18, at 11:00 a.m. indicated R147 was in loresident pushed resident on her side. Resident di injury at time of incident visitors. Causative facto weakness, disorientation determined root cause of another resident. On 6/7/18, at 6:08 p.m. resident lying on floor. Sassessment, neuro chece extremities, complaint of breast and below left brown Call to family/MD with no On 6/7/18, at 5:15 p.m. Assessment: Fall indicate unwitnessed fall, prior to Current interventions: sate of and anti-seizure medicate leans to right when tired Root Cause 6/8/18, for the Resident found on floor factors: weakness/unsted determined root cause of unit. New/Different period place related to root cause fluids and snacks. On 6/19 psychiatrist notes indicate neurocognitive disorders physiological condition, injury at age of 5, progress.	ires. Functional status: iving rehab, occasional r, self-toilets at times. I by another resident. I an IDT Root Cause note ounge, and another int to floor, and she landed id not hit head, and no t. Fall was witnessed by ors: repeated falls, muscle on unspecified. IDT of fall to be pushed by  Kitchen staff found Staff intervention: ocks, moved all of pain directly above left reast. No injuries noted. Intervention: a Falls Risk Post Fall ated R147 had an o ambulating in hall. afety monitoring, est. Psychiatric or if psychotropic medication ation. Functional status: d and ambulating. IDT fall on 6/7/18, at 5:15 p.m. I in dining room. Causative eady gait, dementia. IDT of fall to be: ambulating on od interventions now in use: offer rest period with in/15/18, R147's ated, "Major is due to known history of traumatic brain	2 830			

Minnesota Department of Health

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Minnesota Department of Health							
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPL		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION N	JMBER:	A. BUILDING:		COMP	LETED
		00598		B. WING		00/2	2/2049
		00590				08/2	3/2018
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			2501 RICE	LAKE ROA	ח		
CHRIS J	ENSEN HEALTH & RE	EHABILITATION C		MN 55811			
(X4) ID		TEMENT OF DEFICIENCIE MUST BE PRECEDED BY		ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORM		PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
17.0			,	1,10	DEFICIENCY)		
2 830	Continued From pa	ge 30		2 830			
	and thoughts. Milk [sic] increase in agitation n						
	resolved, controlled. Anxiety disorder, psychotic disorder with delusions, and significant paranoid						
		ons, and significant nd aggression. 'Wel					
		/.' High risk medicat					
		oring weight, screen					
		on a monthly basis. I					
	for sedation and fal	•	,				
		y out weight risks. V					
		ions on a monthly b	asis and				
	attempt taper as ap						
		Writer notified by T					
	[trained medication	aide] that resident h	nad a fall				
		hroom doorway, sitt					
		et up. Noted red spo					
		Fall unwitnessed. F					
		what she was trying	•				
		o poor cognition. Do					
		ng injury to head. Ro					
	•	nelped back into bed					
		gns started. Day nu					
		anager. A Falls Risk					
		e fall 6/28/18, at 12:					
		s in the bathroom, tr					
		ed mark. Fall interve					
		d. Gripper socks, be					
		ital signs, toilet. Und					
	causes: psychiatric	or cognitive, seizure	es/tremors,				
		otropic, anti-seizure:					
	functional status: m	obility issues, cogni	tive				
		und in bathroom do					
		g to get up. No appa	rent injury,				
	six day bowel and b	oladder study.					
	On 6/28/18, IDT Ro	ot Cause for the fal	l on				
	6/28/18, at 12:30 a.	m. indicated resider	nt found in				
	bathroom door way	sitting on butt, tryin	g to get				
	up. No apparent inj						
		ated falls. IDT deter	mined root				
	cause to be: wantin						
		entions now in plac	e related to				

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		NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
CHRIS JENSEN HEALTH & REHABILITATION C  2501 RICE LAKE ROAD DULUTH, MN 55811  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  2501 RICE LAKE ROAD DULUTH, MN 55811  (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLET COMPLETED TO THE APPROPRIATE DATE			00598	B. WING		08/2	3/2018
CHRIS JENSEN HEALTH & REHABILITATION C  2501 RICE LAKE ROAD DULUTH, MN 55811  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  2501 RICE LAKE ROAD DULUTH, MN 55811  (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLET COMPLETED TO THE APPROPRIATE DATE	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS. CITY. S	STATE. ZIP CODE		
CHRIS JENSEN HEALTH & REHABILITATION C  DULUTH, MN 55811  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  DULUTH, MN 55811  PROVIDER'S PLAN OF CORRECTION (X5) COMPLE TAG CROSS-REFERENCED TO THE APPROPRIATE  DATE			2501 RICE				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  OCCUPANTIAL CONTROL OF CORRECTION (X5) COMPLETED TO THE APPROPRIATE  DATE	CHRIS J	IENSEN HEALTH & RE	HABII ITATION C	_	_		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	(X4) ID	SUMMARY STA	<u> </u>		PROVIDER'S PLAN OF CORRECTION	 N	(X5)
	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	.D BE	COMPLETE DATE
2 830 Continued From page 31 2 830	2 830	Continued From pa	ge 31	2 830			
root cause: six day bowel and bladder study. On 7/26/18, at 10/49 p.m. Resident fell near nurses station on 7/26/18, at 3:40 p.m. Resident indicated pain in right hip and was unable to straighten right leg without pain. Unit HUC [health unit coordinator] was witness to fall (See fall packet). Resident was sent to St. Luke's Emergency Room for evaluation and was admitted for further treatment. Family and physician notified of fall. On 7/26/18, a Falls Risk Post Fall Assessment indicated the following: fall at 3:40 p.m.: Desk, while ambulating pain in right hip, current fall interventions: nonskid footwear, rest periods to be offered. 3 or more falls in last six months. Underlying diseases or conditions. Psychiatric or cognitive conditions, ortho/joint/arthritis/seizures. Medications psychotropic, anti-seizures. Functional status: unsteady at times, mostly continent of bladder. Self-toilets at times. Cognitive issues, not able to communicate needs. Lost balance and fell backwards on right side. Sent to Emergency Room for evaluation. On 7/30/18, the IDT Root Cause Review indicated the following: (fall 7/26/18 at 3:40 p.m.) Prior to fall: resident attempted to catch balance and fell backwards by nurse's station. Fall with injury. Review of causative factors: unsteady gait and history of falls IDT determined root cause of fall to be: ambulating on the unit and knee gave out. New/different interventions now in place related to Root Cause: send to Emergency Room. R147 was hospitalized 7/26/18-7/31/18, with a right hip fracture sustained during the fall on 7/26/18, at 11:10 p.m. Resident had unwitnessed fall in bedroom next to bed on 8/2/18, at 3:30 p.m. Resident twas attempting to transfer self to bed. Resident had been toileted	2 630	root cause: six day On 7/26/18, at 10:4 nurses station on 7 indicated pain in rig straighten right leg unit coordinator] wa packet). Resident w Emergency Room f admitted for further physician notified or On 7/26/18, a Falls indicated the follow while ambulating painterventions: nonst offered. 3 or more funderlying disease cognitive conditions Medications psychologically because to Emergency 7/30/18, the IDT Root balance and fe Sent to Emergency 7/30/18, the IDT Root becaused by nurse Review of causative history of falls IDT of because in the serior of the following on the New/different intervence in the process of the fracture sure 7/26/18. R147 returned to 8/2/18, at 1:10 unwitnessed fall in 8/2/18, at 3:30 p.m.	bowel and bladder study. 9 p.m. Resident fell near /26/18, at 3:40 p.m. Resident ht hip and was unable to without pain. Unit HUC [health is witness to fall (See fall //as sent to St. Luke's for evaluation and was treatment. Family and fall. Risk Post Fall Assessment ing: fall at 3:40 p.m.: Desk, ain in right hip, current fall kid footwear, rest periods to be alls in last six months. Is or conditions. Psychiatric or so, ortho/joint/arthritis/seizures. Insteady at times, mostly research at times. It also to communicate needs. It backwards on right side. Room for evaluation. On not Cause Review indicated //26/18 at 3:40 p.m.) Prior to pred to catch balance and fell ets station. Fall with injury. It factors: unsteady gait and determined root cause of fall to the unit and knee gave out. It is factors to be done to the facility on 7/31/18, with a stained during the fall on med to the facility on 7/31/18. p.m. Resident had bedroom next to bed on Resident was attempting to	2 630			

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NU	IMBER:	A. BUILDING:		COMP	LETED
		00598		B. WING		08/2	3/2018
		00000				1 00/2	3/2010
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS II	ENSEN HEALTH & RE	HARII ITATION C	2501 RICE	E LAKE ROA	AD .		
	LITOLIT IILALIII G KI	INABILITATION 6	DULUTH,	MN 55811			
(X4) ID		TEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PRÉFIX		MUST BE PRECEDED BY		PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORM	ATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
					DEL IOIENOTY		
2 830	Continued From pa	ige 32		2 830			
	appeared intact and	d resident was able t	o move				
			o move				
	right hip joint with no signs of pain or impingement. Neuro checks started per policy						
		witnessed. Physiciar					
		otify family (unable to					
		s no answering mac					
		A Falls Risk Post Fall					
	•	8/6/18, for fall 8/2/18					
		in bedroom, attempt					
		. No injury current fal					
		ed, 3 or more falls in					
		ing conditions psych					
	orthopedic/joint/arth		nati io,				
		eizures, antihistamin	es				
		unsteady gait, wheel					
		not able to communi					
		ain level (recent frac					
		g to self-transfer. 15	. ,				
		continue low bed. Or					
		e Review (for fall 8/2					
		ed: Prior to fall reside					
		bedroom next to bed					
		s: unsteady gait/mus					
		ermined root cause of					
		her bed. New/differe					
		n place related to Ro					
	offer to lay down af		-				
		ded by individual res	ident				
	indicated R147 had						
	1/22/18, in the dinir	ng room with no injur	y at 6 p.m.				
		s 3 sleep observation	•				
	day bowel and blad						
		n with no injury at 11	:30 p.m.				
		s PT [physical therap					
	screen, x-ray right f						
		with no injury at 5:40	p.m. the				
		edical workup and pa					
	management.						
		with no injury at 1:25	p.m. the				
		skid footwear, new					

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MILLIFER	ota Department of He	eaith				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00598	B. WING		08/2	3/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
		2501 RIC	E LAKE ROA			
CHRIS J	ENSEN HEALTH & RE	EHABILITATION C DULUTH	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 33	2 830			
	the intervention was in bed after lunch. 2/10/18, in dining roa.m. intervention was periods. 2/23/18, in dining roa.m. intervention was to room. 2/25/18, in dining roa.m. intervention was 3/20/18, in hallway bump on right side intervention placed minutes due to agg 4/6/18, in dining roa 2:10 p.m. the intervention was other residents. 5/8/18 in the lounges the intervention was resident's space. 5/24/18, in another no injury at 10:00. The day bowel and blad 6/7/18 in the dining p.m. the intervention fluids and snacks. 7/26/18, by the nurs to the emergency road surgery on 7/2 7/31/18. 8/2/18, in bedroom intervention was off 8/7/18, in dining road surgery on road su	om/lounge with no injury at tention was medical workup. Dom with no injury at 2:20 p.m. Is to attempt to redirect from the with no injury at 11:00 a.m. Is redirect resident from other resident's room/bathroom with the intervention was to do 3				

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8/9/18, in dining room with no injury at 8:30 p.m.

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00598	B. WING		08/2	3/2018
NAME OF PROVIDER OR SUF	PLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CUDIC IENCEN HEALT		ELIABILITATION C 2501 RICE	E LAKE ROA	ND.		
CHRIS JENSEN HEALTI	IAR	DULUTH,	MN 55811			
PREFIX (EACH DEFI	CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
get stronger to R147 had bet information in the fall with hit falls after returned lacked patien interventions R26's Admission indicated R26 repeated falls R26's annual had cognitive communication R26's care plands and cognitive communication R26's care plands become angular become angular become angular falls related to medication, A cares. On 6/6 scoop mattresseated height checks while then having in indicated R26 indicate that For leave walked On 8/20/18, a walking away walker, RN-H length of the cleast 15 feet. On 8/21/18, a walking throu walker. A hou and NA-H weight in the fall walker. A hou and NA-H weight in the fall walker. A hou and NA-H weight in the fall walker. A hou and NA-H weight in the fall walker. A hou and NA-H weight in the fall walker. A hou and NA-H weight in the fall walker.	on was bused ween the complete control of the contr	is continue with therapy to help walker.  11 and 15 falls (conflicting chart and on the fall log) prior to cture on 7/26/18; and 1 to 3 to the facility. The facility rered interventions, or different ach fall.  Record printed on 8/23/18, diagnoses that included dementia.  dated 6/6/18, indicated R26 and dementia, impaired and had a decline in continence wised 12/31/16, indicated the immaged, and shopped through and believed they were hers. Cated R26 would yell and a redirection, was at risk for cry of falls, impaired mobility, mer's and need for assist with a hand written note indicated ipper socks at bedtime, bed at in-skid footwear. Frequent d, attempt to redirect resident seed behaviors. The care plan culated with walker, but did not yould walk away from walker,	2 830			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00598	B. WING		08/23/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OLIDIO II	ENGENIUEALTU O DI	2501 RICI	E LAKE ROA	.D		
CHKIS J	ENSEN HEALTH & RI	DULUTH,	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830		6 a.m. R26 was observed	2 830			
	walking without walker, leaving it beside the nursing station,and walked up behind RN-H who					
	did not notice she didn't have the walker. NA-G looked at R26 and said, "Where is your walker?"					
		6 a.m. R26 was observed walker. NA-J walked past her				
	twice, a nurse in the area was doing medications, staff for care conferences were at desks, and an NA was in the dining room. After 2 minutes NA-L noticed R26 did not have her walker with her. R26's medical chart was reviewed and indicated					
	the following falls:					
		:17 a.m Found sitting on side the bed in another resident's				
	room. Was alert, sr	miling, stated, "I got down				
		et up." Denied injury or pain. tremities independently.				
		nd walked with staff to her				
		em. Neuro check intact. 2 p.m. One week follow-up				
		al record lacked documentation prior). Resident appears to be				
	at baseline, no resi	dual effects noted post fall, no				
	injuries observed, of assessment.	denies pain at time of				
	On 12/13/17, at 5:0	2 p.m. Resident had				
		witness statements resident rses station and backed up.				
	Another resident re	ached out for her and grabbed				
		ed her back causing resident to ground. Resident laughed				
	and stated, "I'm oka	ay, it doesn't hurt." No				
	apparent injuries. On 12/18/17, at 12:	:51 p.m. Resident had				
	unwitnessed fall in	the hallway. NA reports she n the ground, and found				
	resident lying on right side on the ground. NA notified writer, and writer assessed resident.					

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ROM to all extremities per baseline, denies pain.

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′			LETED
		00598	B. WING		08/23/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2501 RICE	E LAKE ROA			
CHRIS J	ENSEN HEALTH & RE	HABII ITATION C	MN 55811			
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 N	(X5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				BEI ICIENCTY		
2 830	Continued From pa	ge 36	2 830			
	Writer assisted resi	dent to lie down in bed as it				
	was reported she d	id not sleep through the night				
	last night.					
		a.m. Resident had a				
		proximately 8:00 a.m. Writer				
		and noted a golf ball sized				
		head. Resident denied pain				
		ed if she was in pain held the d. Some weakness noted to				
		and weak gait, send resident				
		n for evaluation due to lump				
		left via ambulance at				
	approximately 8:45	a.m. At 11:09 received update				
	from Emergency Re	oom, CT [Cat Scan] of head,				
	shoulder and spine	negative.				
		o.m. R26 had an witnessed fall				
		n next to counter where				
		creamers, are located. She				
		l and railing. She has one inch				
		her head. Neuro/vitals /e all extremities, dry brief;				
		s stayed in her bedroom.				
		back of head. Placed on 15				
	minute checks	back of fields. I ladds off fo				
		5 p.m. Resident found sitting				
	on floor two separa	te times. #1. Sitting on floor on				
	buttocks, holding he	ead. #2. Found in another				
		ing on floor with walker in front				
		ry. Staff monitoring with 15				
	minute checks initia					
		p.m. Unwitnessed fall of				
		sident was lying flat down on nd other things in her hands.				
		3 cm lesion that was bleeding;				
		d bandage. Resident nose was				
		wheelchair, sent to				
		for evaluation at 8:30 p.m.				
		around 12:30 a.m. by				
		pers indicating CT scan was				
		resident to be stiff and sore				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00598	B. WING		08/2	3/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	FHARII ITATION C	E LAKE ROA MN 55811	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	for the next few day at this time. According to the fa 11/30/17, fell in and unnamed injury, at sent to Emergency 12/13/17, fell by nu 3:20 p.m. Intervent nursing note" 12/13/17, in anothe skin tear, at 8:20 p. to evaluate medica visit [there was no be there]. 1/11/018, in resider at 8:00 a.m. The in Emergency Room blood pressure x 3 4/3/18, at nurse's dp.m. The intervention gripper socks at 5/6/18, in main dini p.m. The intervention yinjury and 10:15 p.1 intervention was not medications. 7/13/18, at nurse's a.m. No interventio 7/13/18, in hallway were listed. R26 was Room and returned with no injuries per 8/10/18, at nurse's p.m. The interventi pressures and ther R26's fall logs did redocumentation, and	ys. Resident is sleeping in bed cility fall log R26 had 10 falls: other residents room, with 11:20 a.m. Intervention was Room for evaluation. rses station with no injury at ion indicated, "None see or resident's room, received a.m. The interventions was, MD tions at the next scheduled indication when MD-A would indication when MD-A would and the resident of the revaluation, orthostatic days, Debrox drops [for ears]. lesk with no injury at 11:15 on was to remind staff to put indicate walker. In groom with no injury at 11:45 on was a 7 day sleep study. It at 8:30 p.m. with unnamed in with no injury. The orified MD in regards to fall, no station with no injury at 11:15 ins were listed. It at 7:10 p.m. No interventions as sent to the Emergency at 11:30 a.m. on 7/14/18, CT scan. Station, no injuries, at 6:10 on was 3 day orthostatic blood apy.	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/2	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION C	2501 RICE	DRESS, CITY, SELAKE ROAMN 55811	STATE, ZIP CODE <b>D</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	centered approach SUGGESTED MET The Director of Nur develop, review, an procedures to ensu that occur are fully appropriate interver avoid future falls The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance.		uld and alls, falls use and ace to uld cies and uld ongoing	2 830			
2 900	comprehensive res of nursing services development of a n provides that:  A. a resident wh without pressure so pressure sores unle condition demonstrauthenticates, that  B. a resident wreceives necessary	sores. Based on the ident assessment, the must coordinate the ursing care plan which or enters the nursing pres does not developes the individual's cates, and a physicial they were unavoidable to has pressure sory treatment and service event infection, and	home pp clinical nole; and	2 900			10/2/18

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMI		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00598		B. WING		08/2	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	HABILITATION C	2501 RICE	DRESS, CITY, SELAKE ROAMN 55811	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY F SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 39		2 900			
	by: Based on observati review, the facility for hygiene and glove of wound care for 1 of during wound care, to ensure daily wou wound staging was	ent is not met as evident on, interview, and docailed to ensure proper use was maintained duta residents (R15) obsolin addition, the facility accurate for R15's wo	ument hand uring served r failed ited and		corrected		
	5/25/18, indicated of paraplegia, pressure ulcer of the infection of the skin addition, the MDS in pressure ulcers (Fulloss with exposed of muscle, tendon, ligal ulcer. Slough and/of Epibole [rolled edge tunneling often occillocation. If slough of tissue loss this is Injury). The MDS all	imum Data Set (MDS) liagnoses that included e ulcer of the left butto e coccyx, and local sk and subcutaneous tis ndicated R15 had two ll-thickness skin and to directly palpable fast ament, cartilage or bor reschar may be visibles], undermining and/cur. Depth varies by and reschar obscures the an Unstageable Presso indicated R15 rece, had intact cognition,	d ock, in sue. In Stage 4 issue cia, ne in the e. or atomical extent sure ived				
	Stage 4 healing prewith Methicillin-resisinfection (MRSA; a resistant to many addressing changes. monitor and documappearance, and to	ed 9/21/17, indicated lessure ulcers on admission Staphylococcus at type of staph bacteriantibiotics) and received The care plan directed ent the wound size, stage the wounds. In lan directed staff to fol	ssion, aureus that is d wound I staff to				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00598		B. WING		08/	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION C	2501 RICE	DRESS, CITY, SELAKE ROA	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	facility policies/prote prevention/treatment administer treatment and twice adaly as order had not been done 8/21/18. R15 stated to do it, and stated further stated at time twice a day.  On 8/23/18, at 8:13 was observed to prevent two pressure ulcers buttock areas. RN-to do the wound ca and washed her habasin with warm so basin with plain was bedside table. RN-B and set it to the right water. RN-B donne R15 had history of beds. RN-B applied dressing around R1 RN-B picked up a besprayed the area that he area, and used skin and catheter to garbage. RN-B remperforming hand hy (which contained the out 4 centimeter (croperforming hand hy gloves, opened the gauze dressing around R1 RN-E gauze dressing around R1 RN	ocols for the nt of skin breakdown	e had done ad care g shift on the nurse ed. R15 ot do it see (RN)-B r R15's the left was going bathroom lesis a wash ins on the h basin with plain B stated e wound ed a soiled a site. ser, and ze to wipe ean the wipe in the I without the closet and took /ithout I clean I the clean e, and I gloves,	2 900			

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Minneso	Minnesota Department of Health								
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUME	BER:	A. BUILDING:		COMP	LETED		
		00598		B. WING		08/2	3/2018		
						1 00/2	0/2010		
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE				
CHRIS J	ENSEN HEALTH & RE	FHARII ITATION C		LAKE ROA	.D				
			DULUTH,	MN 55811					
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX		Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION.		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE		
TAG	TREGOLATORY ON E	O IDENTII TIIVO IIVI ORWIXITA	011)	TAG	DEFICIENCY)	1000			
2 900	Continued From pa	ige 41		2 900					
		/giene, donned a clean							
	gloves. RN-B reached into the packet of gauze,								
	took a handful of ga	auze, and dropped ther	n into						
		in. RN-B grabbed anoth							
		nd placed them into the							
		ed into the box with No							
		n and grabbed one tube							
		d squeezed the solutio							
		npty basin. RN-B clean							
		he soapy water, then re							
		gauze soaked in plain v							
		ole gauze pads which s							
		nds. RN-B reached into							
		bed several pieces of o							
		Iry both pressure ulcers							
		es or perform hand hy							
		und care on both press ed into the third basin v							
		soaked in Normal Sali							
		these to start packing t							
		ering the wounds with a							
		yor intervened and ask							
		e soiled gloves as she							
		the wounds. RN-B ren							
		and reached for clean g							
		hand hygiene, RN-B s							
		es. Again the surveyor							
		ked RN-B to wash her l							
		an gloves. RN-B procee							
		ulcers with multiple ga							
		rmal Saline solution, ap							
		top of the pressure ulce							
		s to the skin. RN-B rem							
		es, tossed them in the							
		out performing hand hyo	giene,						
		oves. RN-B moistened t							
		th the wound cleanser,							
		area on R15's left great	toe,						
		a dry. RN-B pickeď up t							
		vatér and plain water, b							

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		, ,	E CONSTRUCTION		SURVEY PLETED
				A. BOILDING.			
		00598		B. WING		08/	23/2018
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHBIC II	ENSEN HEALTH & RI	ELIADII ITATION C	2501 RICE	E LAKE ROA	ND.		
CHKIS J	ENSEN HEALIH & KI	ENABILITATION	DULUTH,	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	nge 42		2 900			
2 000	them to the bathroom and dumped the water in the toilet. RN-B rinsed the basins in the sink, removed her soiled gloves and performed hand hygiene.			2 000			
	documentation, ind 8/14/18: Evening sl A note indicated R1 8/15/18: Day shift, 8/16/18: Day shift, 8/21/18: Evening sl A progress note ind the nurse approach	hift, no wound care c	ility. oleted. oleted. completed. oping when				
	(LPN)-B verified R <sup>2</sup> 8/14/18. LPN-B ver documented as cor and 8/16/18. LPN-E expected to write a completed. LPN-B appointment at 9:00 however, LPN-B wreturned to the faci documentation that or attempted to be appointment. LPN-appointment on 8/1 documentation to enot completed. LPN nurses to reapproarefused or not com to document attem LPN-B also verified nurses should have nurse to approach	B a.m. licensed praction 15 was not out of the initial wound care had mpleted on 8/14/18, 18 stated the nurses wound to explain why stated on 8/15/18, R as not sure when R1 lity, and there was not wound care had been completed after the B stated R15 had not 16/18, and there was explain why wound can had been and all the nupts in the medical relation 8/21/18, and 8/2 to communicated to the R15 to do the wound the R15 had a historial relation R15 had a historial r15 had a historia	facility on d not been 8/15/18, were it was not 15 had an :00 a.m. 5 had on en offered medical no ares were expect the e was urses were cord. 2/18, ne next I care as				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00598	B. WING		08/	23/2018
	PROVIDER OR SUPPLIER	HABILITATION C 250°	EET ADDRESS, CITY, I RICE LAKE ROA UTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	expect the staff to ficontrol protocol for hand hygiene to pre LPN-B further state separate gloves for when cleaning them soiled gloves, wash of gloves before pa applying the clean A On 8/23/18, at 9:21 (DON) stated she will control procedures, nurses were to doc	ure ulcers. and he would ollow standard infection wound care, glove use an event infections to the would RN-B was supposed to each of the pressure ulcent, and was to remove the hands, and apply a clean cking the wounds and	inds. use ers pair ng etion ff			
	wound care was no procedure. RN-B st procedure, she wo washed her hands, wound care. RN-B and this was how st complete the wound not washed her har required on multiple wound care. RN-B for developing infectompleted the would the facility Pressur Management policy licensed nurses to document the resid response to care are	6 a.m. RN-B stated R15's t intended to be a sterile ated if it was a sterile uld have removed her glowand proceeded with the stated this was not the case the understood she was to do care. RN-B verified she and removed gloves at times when completing acknowledged R15 was attions, and she stated she and care as taught.  The Injury/Skin Integrity/Word revised 11/16, directed the daily and/or routinely ents skin condition, the and treatment to the skin.	ves, se, had s t risk had			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
00598	B. WING		08/23/2018	
REHABILITATION C 2501 RIC	E LAKE ROA			
ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
scrub their hands with soap and y for 20 seconds, and staff were and nails.  Ves, Non-Sterile policy dated staff, while wearing gloves, to personal items to prevent staff were also to remove gloves minated as soon as possible, and ash their hands upon removal of  METHOD OF CORRECTION: Nursing or designee could and and an and an and an and an are residents do not develop a unless it is clinically unavoidable, who do have pressure ulcers are oper care and services needed to g, prevent infection and promote locers from developing.  Nursing or designee could ropriate staff on the policies and  Nursing or designee could ring systems to ensure ongoing	2 900			
gastric tubes, gastrostomy tubes, ed on the comprehensive resident	2 930		10/2/18	
	O0598  LIER STREET AD  8 REHABILITATION C	DOS98  LIER  STREET ADDRESS, CITY, SEATH AND THE PREFIX TAGE  PY STATEMENT OF DEFICIENCIES INCY LULL OR LSC IDENTIFYING INFORMATION)  The page 44  Describe their hands with soap and and ly for 20 seconds, and staff were and analis.  The personal items to prevent staff were also to remove gloves aminated as soon as possible, and ash their hands upon removal of  METHOD OF CORRECTION:  Nursing or designee could wand/or revise policies and ensure residents do not develop a unless it is clinically unavoidable, who do have pressure ulcers are roper care and services needed to g, prevent infection and promote ulcers from developing.  Nursing or designee could bropriate staff on the policies and forming systems to ensure ongoing  FOR CORRECTION: Twenty-one  10525 Subp. 7 B. Rehab - astrostomy tubes, and on the comprehensive resident.	DOSSS  LIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2501 RICE LAKE ROAD DULUTH, MN 55811  PROVIDER'S PLAN OF CORRECTION ENCY MUSTS BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)  The page 44  Descrub their hands with soap and lift or 20 seconds, and staff were and nails.  Ves, Non-Sterile policy dated as taff, while wearing gloves, to personal items to prevent staff were also to remove gloves aminated as soon as possible, and ash their hands upon removal of  METHOD OF CORRECTION: Nursing or designee could y, and/or revise policies and ensure residents do not develop a unless it is clinically unavoidable, who do have pressure ulcers are roper care and services needed to g, prevent infection and promote alcers from developing.  Nursing or designee could propriate staff on the policies and sorries needed to g, prevent infection and promote alcers from developing.  Nursing or designee could propriate staff on the policies and services needed to g, prevent infection and promote alcers from developing.  Nursing or designee could propriate staff on the policies and services needed to g, prevent infection and promote alcers from developing.  Nursing or designee could propriate staff on the policies and services needed to g, prevent infection and promote alcers from developing.  Nursing or designee could propriate staff on the policies and services needed to g, prevent infection and promote alcers from developing.  Nursing or designee could propriate staff on the policies and satrostomy tubes, gastrostomy tubes, gastrostomy tubes, ed on the comprehensive resident	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00598		B. WING		08/:	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION C	2501 RICI	DRESS, CITY, SELAKE ROAMN 55811	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 930	B. a resident w gastrostomy tube o appropriate treatme aspiration pneumor dehydration, metab	who is fed by a nasog r feeding syringe rec ent and services to p nia, diarrhea, vomitin olic abnormalities, a lcers and to restore,	eives the revent g,	2 930			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a tube feeding was given as ordered, and medications were given according to standards of practice through a gastrostomy tube for 1 of 2 residents (R148) reviewed for tube feedings.			corrected			
	Findings include:	Minimum Data Set (N	NDS)				
	dated 8/15/18, indic dysphagia (difficulty injury (TBI) and mu the MDS identified I R148's Physician O	cated diagnoses that y swallowing, trauma scle weakness. In a R148 received tube order dated 8/8/18, in	included tic brain ddition, feeding.				
	tube feeding), 65 m hours continuously addition, a physicial R148 was to receive	for Jevity 1.0 (nutriticalliliter (ml) per/hour from 8:00 a.m. to 5:00 n order dated 8/9/18 e 150 ml water flush the four times daily for	for 21 00 a.m. In , indicated es via				
	did not receive anyt	ated 8/16/18, indicate thing by mouth, and ng. The care plan inc	she				

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STATEMENT OF DEFICIENT AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00598	B. WING		08/2	3/2018
NAME OF PROVIDER OR S	SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CUDIC IENCEN LIEA	TILOD	ZUARU ITATION C 2501 RICI	E LAKE ROA	.D		
CHRIS JENSEN HEA	-IH & KI	DULUTH,	MN 55811			
PREFIX (EACH D	EFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 930 Continued	From pa	age 46	2 930			
nursing wa free water follow facili medication	Continued From page 46  nursing was to administer the tube feeding and free water flushes via g-tube, nursing was to follow facility tube feeding policy/protocol, and medications were administered via g-tube per physician order.  On 8/22/18, at 8:04 a.m. registered nurse (RN)-D					
was observed RN-D crust separate populated (mEq) in fix was going At 8:11 a.m to the bath graduate or indicated separated in was mixed the separation in serted the administer poured the barrel and clamped the was mixed in the was mixed in the was mixed in the separation in serted the series and clamped the was mixed in the was mixed in the separation in the sepa	red prepried seviced seviced seviced sevice ounced to give a large red sevice sevice sevice seviced the seviced seviced this seviced this seviced seviced the seviced seviced the seviced seviced this seviced sev	a.m. registered nurse (RN)-D paring R148's medications. It are different medications in gs and mixed two packets of an Chloride 20 milliequivalent as of water. RN-D stated she all the medications via g-tube. It arrived at R148's room, went dobtained 200 ml of water in a RN-D approached R148, going to administer art her enteral feeding via dothe bedside table and set of with Potassium Chloride dothe rest of R148's morning and in little plastic bags. After N-D was picked up the g-tube, osure, and inserted a syringe ding port as she listened with a ck for tube placement. RN-D at the g-tube port and and plunger. RN-D into the g-tube port and and plunger. RN-D are and poured another 10 ml of and poured another 10 ml of and poured another 10 ml of and poured the crushed and into the water in the barrel, adminsitered the medications. With a 10 ml flush of water. Sprocess of emptying the medications five times without				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/2	23/2018
NAME OF PROVI	DER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS JENSE	EN HEALTH & RE	EHABILITATION C		LAKE ROA MN 55811	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
ther into water flus the sep RN-water rem of water water had prolowas med mix there has barrifolic RN-star On med usir adminot RN-was have from	the bathroom a er. RN-D return hed the tube. R crushed powde arate occasions D stated she have to complete to every the result of the result o	I. Once finished, RN and obtained another ed to R148's bed sid N-D continued to ad red medications on the followed by water flad used a total of 35 he water flushes. RNs, dumped the remainer hands, and left the fact that was to receive a day. RN-D store water because short water because short water because short because short as a day. RN-D stated she had asked RN-E, we the powder into the mil to 10 ml of water, flush of the same and not know the policias why she had asked she was going to he	r 200 ml of le, and minister two lushes. 0 ml of N-D ining 50 ml he room e 150 ml of tated she he had a and she To let the ad not tering tho told syringe, and then nount. y on tube ed RN-E. old off on e d in water g-tube ld have ater flush). The feeding should be ding verified	2 930			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/:	23/2018
	PROVIDER OR SUPPLIER	EHABILITATION C	2501 RICE	DRESS, CITY, S E LAKE ROA MN 55811	STATE, ZIP CODE D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 930	At 9:02 a.m. RN-E a had gotten an order three hours due to a would re-start the two on 8/22/18, at 1:40 had not demonstrate to medication admir RN-F stated all the clinical check list.  On 8/22/18, at 1:49 (DON) stated she was to dissolve the mediadministering them. The DON stated RN physician orders for have started the two and if not, to get an SUGGESTED MET. The Director of Nur develop, review, an procedures to ensur feedings are received services needed. The Director of Nur	p.m. the director of lications in water before according to the factor of the water glicensed nursing states. The director of the water glicensed nursing states according to the factor of the water flushes, as the feeding timely as the feedin	ed she ding for and n. he RN-D s related g-tube. ff had a nursing the nurse ore ility policy. bwed the and should ordered,	2 930			
	The Director of Nur develop monitoring compliance.	sing or designee cou systems to ensure of R CORRECTION: To	ongoing				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00598	B. WING		08/2	3/2018
	PROVIDER OR SUPPLIER	HABILITATION C 2501 RIC	DDRESS, CITY, S E LAKE ROA , MN 55811	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 930	Continued From pa	ge 49	2 930			
2 945	Subpart 1. Nursing personnel must det served diets as pre help in eating must receipt of the meals unhurried and in a renhances each res Adaptive self-help contribute to the reseating. Food and fl be observed and de reported to the nurs resident's care duri observation of a de	g personnel. Nursing ermine that residents are scribed. Residents needing be promptly assisted upon and the assistance must be manner that maintains or ident's dignity and respect. Devices must be provided to sident's independence in uid intake of residents must eviations from normal se responsible for the ng the work period the viation was made. Persistent as must be reported to the	2 945			10/2/18
	by: Based on observatireview, the facility facquipment was pro (R117) reviewed for R117's Admission Findicated R117's dia (difficulty swallowing).	ent is not met as evidenced on, interview, and document ailed to ensure adaptive eating vided for 1 of 1 residents r nutrition.  Record printed on 8/23/18, agnoses included dysphasia g) and cancer of throat or		corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER	1	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	,	
CHRIS J	ENSEN HEALTH & R	EHABILITATION C		E LAKE ROA MN 55811	ND.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 945	dated 5/4/18, indicated to sequencing coordination. The Marequired assistance mechanical soft conformation of pureed for break apart without was to work toward independence with the coop plate [plate with the c	atted R117 had difficult errors and declining MDS further identified with eating, require insistency diet (choppeds, and foods that retal a knife). R117's good resident highest leverating.  The call of the call	d R117 d a ped, padily al listed el of  I Speech use at all  I scoop  se (RN)-H dietary pess was etary staff sed on therapy I the ended by es continue  TION: uld and ed	2 945			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/23/2018		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CHRIS JI	ENSEN HEALTH & RE	FHABII ITATION C	E LAKE ROA MN 55811	<b>VD</b>			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 945	educate all appropring procedures. The Director of Nurdevelop monitoring compliance.  TIME PERIOD FOR (21) days.	rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing	2 945			40/0/40	
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi  Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.		21015			10/2/18	
	by: Based on observati failed to ensure pro stainless steel serv formation and pote deficient practice ha	ent is not met as evidenced ion and interview, the facility oper drying and storage of ing pans to prevent bacteria ntial for foodborne illness. This ad the potential to affect all ate food prepared in the facility		corrected			
	observation of the k manager (DM), fou pans were checked pots and pans sink away wet. Two more	p.m. during the initial kitchen with the dietary restainless steel steam table in the storage area near the Two of the pans had been put the stainless steel pans stored were also found to be stored					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/2	3/2018
	PROVIDER OR SUPPLIER  ENSEN HEALTH & RE	HABILITATION C 2501 RIC	DDRESS, CITY, S E LAKE ROA , MN 55811	STATE, ZIP CODE D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21015	be used again, and dried before being so On 8/23/18, at 2:07 observation of the known pans were checked cooks area. Of the to be wet and anoth food residue remain DM verified the wet SUGGESTED MET The Director of Died develop, review, an procedures to ensure stored clean an The Director of Died all appropriate staff procedures. The Director of Died monitoring systems compliance.	ed the pans were put away to stated the pans were to be air stacked for use.  p.m. during a second sitchen, four stainless steel on a storage shelf in the four pans, one pan was noted her had been put away with hing on the pan surface. The pans and the soiled pans.  CHOD OF CORRECTION: tary or designee could d/or revise policies and re kitchen cook and bakeware d dry. tary or designee could educate on the policies and				
21025	Potentially hazardor 40 degrees Fahren or below, or 150 de centigrade) or abov food" means any fo and temperature corapid and progressi toxigenic microorga	o Food Temperatures  us food must be maintained at heit (four degrees centigrade) grees Fahrenheit (66 degrees re. "Potentially hazardous od subject to continuous time ontrols in order to prevent the ve growth of infectious or unisms.  ent is not met as evidenced	21025			10/2/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/2	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION C	2501 RICI	DRESS, CITY, SELAKE ROAMIN 55811	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21025	by: Based on observation review, the facility for served at a palatabe for 1 of 6 residents  Findings include:  R4's Admission Residementia and Alzher R4 had diagnoses to dementia and Alzher R4's quarterly Mining 5/3/18, indicated R4 mental status, and and encouragement R4's diet order dated diet, low fat/cholest care plan printed 8/edentulous (lacking low sodium, low fat honey (textured) lique on 8/20/18, at 4:54 temperatures taken included french frie (F) and mashed pout to beginning food simprove the temper DA-A began serving on 8/22/18, at 1:20 were served to residential registered a temper pureed spinach was Food temperatures	on, interview, and dealled to ensure food le and appetizing ter (R4) receiving pured cord printed 8/23/18 that included unspectations and makes at 182 degrees at 135 degrees Fatatoes at 132 degrees ervice. No action was returned to these menusyments at the last foodents, pured meatles at 100 degrees at 100 degrees at 110 degrees F with were not observed the meal service and	was mperature ed food.  , indicated sified  s) dated paired stance, ng. a low salt diet. R4's was l a pureed, t with  od )-A hrenheit es F prior es taken to u items.  d trays oaf es F, and n DA-B. to have	21025	corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED		
		00598		B. WING		08/2	3/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	HABILITATION C	2501 RICE	DRESS, CITY, SELAKE ROAMN 55811	STATE, ZIP CODE <b>D</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21025	On 8/23/18, at 11:19 received was some On 8/23/18, at 1:33 (DM) stated when for in the dining rooms supposed to call the would bring the foor re-heat it.  SUGGESTED MET The Director of Died develop, review, an procedures to ensu the appropriate term The Director of Died all appropriate staff procedures.	9 a.m. R4 stated the fortimes not hot.  p.m. the dietary manapod temperatures of hare low, food service set kitchen and kitchen and back to the kitchen and back to the kitchen and dor revise policies and re food is served hot apperatures.  Earry or designee could on the policies and tary or designee could and tary or designee could the policies and tary or designee could tary or designee.	ager ot foods staff are staff and ON: d and at educate	21025			
21035	(21) days.	R CORRECTION: Twe	•	21035			10/2/18
21000	Snacks Subp. 2. Snacks. evening snacks dai snacks available ar of that availability. This MN Requirements	The nursing home mustly. "Offer" means having the resident	st offer ing aware enced	21000	corrected		10,2,10
	review, the facility fa	on, interview, and doc ailed to ensure substal re offered for 3 of 3 re	ntial		corrected		

Minnesota Department of Health

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/23/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	-HABII ITATION C	E LAKE ROA MN 55811	.D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21035	Continued From pa	ige 55	21035			
	(R128, R4, R118) who received meals in the Cedar unit dining room and who were reviewed for dining services.					
	Findings include:					
	-Breakfast: 8:20 a.r -Lunch: 12:20 p.m. -Dinner: 5:00 p.m. There were 15 hou posted dinner and	rs, 25 minutes between the				
	indicated R128 had	I diagnoses that included aviors, anemia, and muscle				
		mary Report, dated 8/23/18, s to receive a pureed diet.				
	R128's quarterly Minimum Data Set (MDS) dated 8/8/18, indicted R128 had severely impaired cognition, was sometimes able to understand others and was sometimes able to be understood. R128's MDS further indicated R128 required extensive assistance with all activities of daily living (ADLs) including eating, and she weighted 114 pounds.					
	had lost weight dur a body mass index acceptable range. I	ated 5/5/18, indicated R128 ing the last 3 years resulting in (BMI) at the lowest of an R128 was to receive increased utritional supplements at nes.				
	her wheelchair, in t	a.m. R128 was observed in he dining room of the Cedar oservations began on 8/22/18,				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/23/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
CHRIS J	ENSEN HEALTH & RE	-HABII ITATION C	LAKE ROA MN 55811	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	.D BE	(X5) COMPLETE DATE
21035	Continued From pa	ge 56	21035			
	from 7:47 a.m. unti	l 9:22 a.m.				
	her wheelchair in the not seated at a table juice. R128 was not beverage or an action continued to sit in high grinding her teeth upushed in her wheel window. R128 was food item. From 9:0 was observed with At 9:22 a.m. a staff R128 to eat her breakt snack to tide her overeceived her breakt 57 minutes past the the Cedar Unit breakt	a.m. R128 was observed in the unit dining room. R128 was e, and did not have coffee or of approached, offered a livity at any time. R128 was er wheelchair, sometimes until 8:59 a.m., when R128 was elchair to at table near the still offered no beverage or of a.m. until 9:20 a.m., R128 her head forward as if dosing. person sat down to assist eakfast.  28 offered coffee, juice, or a ver until breakfast. R128 fast meal at 9:22 a.m., which is a posted time of 8:25 a.m. for akfast meal. This was 16 after the posted dinner time for				
	printed 8/23/18, ind needed (PRN). R12 she had 1 bedtime	Oocumentation Survey Report icated HS snacks are as 28's documentation indicated (HS) snack in June (but IS snack in July (before in August.				
	R4 had diagnoses	cord dated 8/23/18, indicated that included unspecified er's disease, and dysphagia g).				
		num Data Set (MDS) dated 4 had moderately impaired				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/	23/2018
	PROVIDER OR SUPPLIER	EHABILITATION C	2501 RICE	DRESS, CITY, S E LAKE ROA MN 55811	TATE, ZIP CODE <b>D</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21035	R4's diet order date diet, low fat/cholest R4's care plan print edentulous (no teet sodium, low fat, low (textured) liquids.  Evening snack reconst received. The with a notation that not documented.  R118's Admission Findicated R118 had hemiplegia and dys  R118's annual Mini 02/02/18, indicated assistance with eat physical assistance.  R118's care plan darequired extensive nutrition portion of total assistance, to to sit on R118's left.  R118's evening sna 8/22/2/18, were required extensive of the sit on 8/3/18. The Doc provided for July 20 one evening snack between the hours for the month.  On 8/23/18, at 3:13	ed 4/08/18, was for a erol 3 gram sodium. ted 8/16/18, indicate th), and received a power cholesterol diet with ords for R4 were requested as a consumed to the core dated 8/23/18 diagnoses that include the core plan include assist of one for all reference in the care plan includensive hands-on assist incheding the meal, and	d R4 was sureed, low h honey  uested but returned by R4 were  8, uded  6) dated sive providing  d R118 meals. The ed stance to instruction  /18 - byided to 9:50 p.m. Report 118 ate snacks 00 a.m.	21035			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/2	23/2018
	PROVIDER OR SUPPLIER	EHABILITATION C	2501 RICE	DRESS, CITY, S E LAKE ROA MN 55811	STATE, ZIP CODE D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY I SC IDENTIFYING INFORMA'	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21035	hungry during the esomething to eat. Nor special diets, an refrigerator to see it specifically for that made an effort to grapecific snack order to the recipients be she knew who ate at them sitting outside resident couldn't fewith the resident and what was eaten for On 8/23/18, at 3:13 (LPN)-L stated staffiguice to residents. Let do not want an every ended around 6:00 residents do get evel labeled snacks, or stock supply if there snack. For resident would offer some emed passing proce residents are sound felt lucky to get their stated a lot of the rest they had three good again." LPN-L said ones who record even the stated and staffintake. When asked intake for R118, she health record and staffintake.	vening, she would given ing, she would given in the back room in the back room in the year a labeled so individual. NA-J said in the labeled snack in the labeled snack in the interest in the year of the yea	I check om nack she s, abetics, stated seeing if a vould stay computer cal nurse ream or esidents supper abetic specially m the ly labeled , LPN-L of the tof the so she nents eating s are the er (DM) taff nack ectronic aff	21035			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00598	B. WING		08/23/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	-HABII ITATION C	E LAKE ROA MN 55811	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21035	The facility policy M 1/27/18, directed no between a substantion breakfast the follow snack is offered to policy directed the fand offering such s 16 hours between the following day break the policy, was respevening snack, and snack in the electron.  The facility policy H dated 1/18, directed offered an HS snack facility would have stopper snacks wound have supper snacks word nursing station for estable snacks were to be record.  SUGGESTED MET The Director of Nurdevelop, review, and procedures to ensure substantial evening hours between the The Director of Nurdevelop monitoring compliance.	fleal Times/Frequency dated of more than 14 hours elapse tial evening meal, and ving day unless a nourishing residents at bedtime. The facility offer nourishing snacks, nacks allows there to be up to the evening meal and the fast meal. Nursing staff, per ponsible for offering an the for documentation of the	21035			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				A. BOILDING.			
		00598		B. WING		08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	HABILITATION C		E LAKE ROA MN 55811	AD.		
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIE		ID ID	PROVIDER'S PLAN OF CORRECT	TON	(X5)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETE DATE
21390	Continued From pa	ge 60		21390			
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control			21390			10/2/18
	control program muprocedures which pare collection to identify residents;  B. a system for control of outbreaks.  C. isolation and reduce risk of trans.  D. in-service exprevention and con.  E. a resident had immunization progration and con.  F. the development of the prevention and F. the development of the prevention and F. the development of the prevention and F. the development of the products, including defined in part 4658.  G. a system for the products which affed disinfectants, antised incontinence products which affed disinfectants and ards of the products of the products which affed disinfectants and ards of the products which affed disinfectants are the products which affed disinfectants and ards of the products which affed disinfectants are the products which are the products which are the products which affed disinfectants are the products which are the products which are the products which are the products are the products which are the products are the products are the products which are the products	ealth program includ am, a tuberculosis p 8.0810, and policies ent care practices to treatment of infection ent and implement policies and infection of a tuberculosis progra.0815; reviewing antibiotic review and evaluation control, septics, gloves, and	and ving: c data ns in tion, and ses; ns to agents; ing an rogram as and assist in ns; ation of control ram as use; on of such as ess of a control. denced ocument er hand		corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		08/	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION C	2501 RICE	DRESS, CITY, SELAKE ROAMN 55811	ETATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From page 61		21390				
	5/30/18, indicated F cognition, and was bladder. R4's MDS extensive assistant toileting.  On 8/23/18, at 7:43 entered R4's room care. NA-O put on with washing his far peri areas. NA-O rewas wet with urine, removing the soiled putting on a new go changing the garbaheight using an electronic part of the company of the soiled putting on a new go changing the garbaheight using an electronic manufacture.	mum Data Set (MDS R4 had moderately in occasionally inconting also indicated he receive with personal hygo a.m. nursing assistate offer breakfast and gloves prior to assiste e, washing under a semoved an incontine and completed care all gloves, NA-O assistent, pulling up the conge, and adjusting the octric control. After the room and removed leads	mpaired ment of quired iene and  ant (NA)-0 and morning ting R4 rms, and ent pad that es. Without sted R4 in omforter, e bed at, NA-O				
	On 8/23/18 at 7:58 touch items after prostated they had been glove removal, but R128's Admission Findicated R128 had dementia with behavior R128's quarterly MR128 had severely sometimes able to sometimes able to further indicated R2 assistance with all assistance wi	a.m., NA-O stated heroviding peri cares. Nen taught to wash has sometimes they forgod Record printed 8/23/1 diagnoses that including aviors, and muscle with the state of the	NA-O ands after got. 18, uded veakness. licted was and was 8's MDS ve ng (ADLs),				
	R128's care plan da	ated 5/5/18, indicate	d R128				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		00598		B. WING		08/:	08/23/2018	
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION C	2501 RICI	DRESS, CITY, S E LAKE ROA MN 55811	TATE, ZIP CODE D			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE / MUST BE PRECEDED B\ SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21390	had dementia with neurogenic bladder after any incontiner  On 8/22/18, at 9:36 from the dining rook R128 onto the toile wheelchair next to to NA-N assisted R12 two hands, and usin R128 to standing, the toilet. After R12 wiped R128's periapulling up her pants moved the wheelch handles, took off the removed the gloves hygiene, NA-N flust transfer belt and pugarbage bag, place unlocked the wheel bathroom door han R128's wheelchair got to the soiled util washed her hands.  On 8/22/18, at 9:45 realized she forgot had been taught to removal. NA-N also touching "dirty" item until she was in the hands.  On 8/23/18, at 8:20 (LPN)-B stated the touched the patient their hands. LPN-B	behaviors, history of , and to provide peri	R128 assist S's gloves. ars with sisted sitting on et, NA-N 128 in oves, NA-N 1 the then g hand up the ew up the container, sed the and push en NA-N d and he and she ove s still to wait o wash ical nurse erson nitized ave skin	21390				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00598	B. WING		08/2	23/2018
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	HABILITATION C 2501 R	ADDRESS, CITY, S ICE LAKE ROA H, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21390	removal, then staff clothing bed height, On 8/23/18, at 12:2 (DON) stated she e or sanitized immedi SUGGESTED MET The Director of Nur develop, review, an procedures to ensu completed. The Director of Nur educate all appropriocedures. The Director of Nur develop monitoring compliance.	can go back and adjust				
21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volumed the shall provides	A.04 Subd. 3 Tuberculosis ntrol e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR) include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of etechnical assistance intation of the guidelines.				10/2/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00598	B. WING		08/23/2018	
	PROVIDER OR SUPPLIER	2501 RICE	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	FHARII ITATION C	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21426	•	ance with this subdivision must	21426			
	by: Based on interview agency failed to en R412, R108) Tuber were completed an In addition, the faci employees (E-A, E-	ent is not met as evidenced and document review, the sure 3 of 5 residents (R142, rculin Skin Test (TST) results d appropriately documented. lity failed to ensure 2 of 5 -B) TST results were priately per State regulation.		corrected		
	R142 received a fir 10:47 p.m. and it w p.m. which was les addition, a second	I to the facility on 7/15/18. st step TST on 7/16/18, at as read on 7/18/18, at 10:44 s than 48-72 hours. In step TST had been 28/18, however, the result was				
	R412 had a first ste	I to the facility on 8/15/18. EP TST administered and read 8/18, however no symptom upleted.				
	was administered a	I to the facility on 7/5/18. R108 a first step TST on 7/5/18, at s read on 7/7/18, at 5:18 p.m. urs.				
	On 8/1/18, at 2:57	p.m. registered nurse (RN)-E				

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STATEMENT OF DEFICIENCIES (X1)

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		` ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BOILDING.			
		00598		B. WING		08/2	23/2018
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS JE	ENSEN HEALTH & RE	HABII ITATION C		ELAKE ROA MN 55811	.D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21426	the symptoms screet TST and reading the E-A's personnel file 6/25/18. E-A had a 6/25/18, and read 6 was administered on however the results no induration in mill E-B's personnel file 6/18/18. E-B had a 7/26/18, at 9:00 p.m 2:40 p.m. with result negative which was On 8/21/18, at 11:50 resources (HR)-A v HR-A stated she not early, and the indurative result.  On 8/22/18, at 2:10 (DON) stated she were reading the TSTs were further stated all ad symptoms screening residents TSTs were SUGGESTED MET The Director of nurse review and revise p staff and monitor to (TST) are read, rest that employees are (TB) using a symptomingle step IGRA (In the content of the conten	ified concerns with compening, missed second stee TST results.  identified a hire date of first step TST administer /28/18. A second step TS n 7/3/18, and read 7/6/18 we identified as negative	red on ST 8, red on at d man s. g read for sing be ON nave d all mely. V: uld train Tests ssure is a	21426	DEI IGIENOT)		

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00598	B. WING		08/2	3/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	HABII ITATION C	E LAKE ROA MN 55811	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21925	Residents of HC Fassiball not be arbitrar Residents must be proposed discharge justification no later discharge from the transfer to another notice shall include the proposed action telephone number of ombudsman pursua Act, section 307(a)(of this right, may chnotice period ends. shortened in situatic control, such as a creview, the accomman residents, a change treatment program, resident's welfare, or prohibited by the pupaying for the resident the medical record. This MN Requirement by:  Based on interview facility failed to notificated transfer for reviewed for hospital.	ers and discharges. Residents ily transferred or discharged. notified, in writing, of the er or transfer and its than 30 days before facility and seven days before facility and seven days before room within the facility. This the resident's right to contest n, with the address and of the area nursing home fant to the Older Americans (12). The resident, informed to be to relocate before the one outside the facility's letermination by utilization modation of newly-admitted in the resident's own or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a faccommodate new residents from assignments.  The notice period may be considered in the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless about a significant or the resident's own or another or nonpayment for stay unless and the resident's own or another or n	21925	corrected		10/2/18
		inimum Data Set (MDS) dated agnoses which included				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00598		B. WING		08/	23/2018
	ROVIDER OR SUPPLIER	HABILITATION C	2501 RICE	E LAKE ROA	STATE, ZIP CODE . <b>D</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	R94's MDS also indithe facility from the the same day R94 whospital.  On 6/23/18, R94's pwas admitted to the note further indicated 102.1 Fahrenheit (Fprovider at the hospsend R94 back to the another temperature indicated at 11:30 p 101.7 F, and R94 windight.  On 6/25/18, R94's pwas re-admitted to admitting diagnosis intravenous (IV) and On 8/22/18, at 10:1 service SS-A verified the hospital on 6/23 SS-A verified she hombudsman of R94 On 8/22/18, at 2:20 ombudsman verified R94's discharge to A policy on notificating requested but not purposed to suggest the suggest of the Director of Socidevelop, review, and suggest and suggest of the suggest of the process of the suggest of the Director of Socidevelop, review, and suggest of the suggest of the suggest of the Director of Socidevelop, review, and suggest of the suggest of the process of the suggest o	gia and neurogenic belicated R94 had admit hospital on 6/23/28, awas discharged back progress note indicated facility from the hospital who gave an ordine hospital if R94 spille. The progress note indicated the facility on 6/25/18 of sepsis, and an ordicated the facility on 6/25/18 of sepsis, and an ordicated the facility on 6/25/18 of sepsis, and an ordicated the facility on 6/25/18 of sepsis, and an ordicated the facility on 6/25/18 of sepsis, and an ordicated the facility on 6/25/18 of sepsis, and an ordicated the facility on 6/25/18 of sepsis, and an ordicated the facility on 6/25/18 of sepsis, and an ordicated the facility on 6/25/18 of sepsis, and an ordicated the facility on 6/25/18 of sepsis, and an ordicated facility of sepsis facility of sep	ed R94 pital. The ature of called the er to ked further re was a pospital at ed R94 g, with der for social charged to 25/18. pospital.	21925			

Minnesota Department of Health

STATE FORM 6899 55P911 If continuation sheet 68 of 69

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/2	23/2018
	PROVIDER OR SUPPLIER	HARILITATION C 2501 RICI	DRESS, CITY, S E LAKE ROA MN 55811	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21925	The Director of Soc educate all appropr procedures. The Director of Soc develop monitoring compliance.	ge 68 sial Services or designee could iate staff on the policies and sial Services or designee could systems to ensure ongoing R CORRECTION: Twenty-one	21925			

Minnesota Department of Health STATE FORM

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	Evacuation and Relocation Plan				
	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.				
	Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2.				
	18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3				
K712	Fire Drills				
	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.  18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K741	Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:  (1) Smoking shall be prohibited in any room, ward, or compartment where				
	flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.				
	(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.				
	<ul><li>(3) Smoking by patients classified as not responsible shall be prohibited.</li><li>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</li></ul>				
	(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.				
	(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.				
	18.7.4, 19.7.4				
K751	Draperies, Curtains, and Loosely Hanging Fabrics				
	Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall.				
	18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	Upholstered Furniture and Mattresses				
	Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered.				
	Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered.				
	Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered.				
	Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date.				
1/770	18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4				
K753	Combustible Decorations				
	Combustible decorations shall be prohibited unless one of the following is met:				
	Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.				
	Decorations meet NFPA 701.				
	<ul> <li>Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.</li> </ul>				
	Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6.				
	The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present.				
	18.7.5.6, 19.7.5.6				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K754	Soiled Linen and Trash Containers  Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended.  Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent.  18.7.5.7, 19.7.5.7		WILI		
K771	Engineer Smoke Control Systems  2012 EXISTING  When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises.  19.7.7  2012 NEW  When installed, engineered smoke control systems are tested in accordance with NFPA 92, Standard for Smoke Control Systems. Test documentation is maintained on the premises.  18.7.7				
K781	Portable Space Heaters  Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius).  18.7.8, 19.7.8				
K791	Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241.  18.7.9, 19.7.9, 4.6.10, 7.1.10.1				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	Health Care Facilities Code - Other  List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567.				
K901	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)				
K902	Gas and Vacuum Piped Systems – Other List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 5 (NFPA 99)				
K903	Gas and Vacuum Piped Systems – Categories  Medical gas, medical air, surgical vacuum, WAGD, and air supply systems in which failure is likely to cause major injury or death are designated:  □ Category 1. Systems in which failure is likely to cause minor injury to patients are designated.  □ Category 2. Systems in which failure is not likely to cause injury, but can cause discomfort is designated.  □ Category 3. Deep sedation and general anesthesia are not administered when using a Category 3 medical gas system.  5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)				
K904	Gas and Vacuum Piped Systems – Warning Systems All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K905	Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations				
	containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening."				
14000	5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)				
K906	Gas and Vacuum Piped Systems – Central Supply System Operations Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers.  5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)				
K907	Gas and Vacuum Piped Systems – Maintenance Program				
	Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	Gas and Vacuum Piped Systems – Inspection and Testing Operations				
	The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required.  5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)				
K909	Gas and Vacuum Piped Systems – Information and Warning Signs Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)				
K910	Gas and Vacuum Piped Systems – Modifications Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)				
K911	Electrical Systems – Other  List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.  Chapter 6 (NFPA 99)				
K912	Electrical Systems – Receptacles  Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover.  If used in patient care room, ground-fault circuit interrupters (GFCI) are listed.  6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K913	Electrical Systems – Wet Procedure Locations  Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection.  6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2				
K914	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 ≤ 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 manual test is performed at intervals ≤ 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)				
K915	Electrical Systems – Essential Electric System Categories  ☐ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES.  ☐ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES.  ☐ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours.  3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K916	Electrical Systems – Essential Electric System Alarm Annunciator		IVIEI		
	A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator.				
	6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)				
K917	Electrical Systems – Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)				
K918	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 and readily identifiable. 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)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K919	Electrical Equipment – Other  List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99)				
K920	Electrical Equipment – Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.  10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K921	Electrical Equipment – Testing and Maintenance Requirements				
	The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training.  10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8				
K922	Gas Equipment – Other				
	List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.  Chapter 11 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K923	Gas Equipment – Cylinder and Container Storage				
	≥ 3,000 cubic feet				
	Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.				
	> 300 but <3,000 cubic feet				
	Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.				
	≤ 300 cubic feet				
	In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.				
	A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING".				
	Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.				
	11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)				
K924	Gas Equipment – Testing and Maintenance Requirements				
	Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed.  11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K925	Gas Equipment – Respiratory Therapy Sources of Ignition				
	Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion.  11.5.1.1, TIA 12-6 (NFPA 99)				
K926	Gas Equipment – Qualifications and Training of Personnel				
.025	Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment.  11.5.2.1 (NFPA 99)				
K927	Gas Equipment – Transfilling Cylinders				
	Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, <i>Transfilling of High Pressure Gaseous Oxygen Used for Respiration</i> . Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K928	Gas Equipment – Labeling Equipment and Cylinders				
	Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting.				
K929	Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds  Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99).				
K930	Gas Equipment – Liquid Oxygen Equipment  The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99).  11.7 (NFPA 99)				
K931	Hyperbaric Facilities  All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99.  Chapter 14 (NFPA 99)				
K932	Features of Fire Protection – Other  List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire  Protection requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or  NFPA standard citation, should be included on Form CMS-2567.  Chapter 15 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K933	Peatures of Fire Protection – Fire Loss Prevention in Operating Rooms Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers:  • packaging is non-flammable.  • applicators are in unit doses.  • Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify:  • application site is dry prior to draping and use of surgical equipment.  • pooling of solution has not occurred or has been corrected.  • solution-soaked materials have been removed from the OR prior to draping and use of surgical devices.  • policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use.  Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually.  15.13 (NFPA 99)		WEI		

Name of Facility 20	2012 LIFE SAFETY CODE
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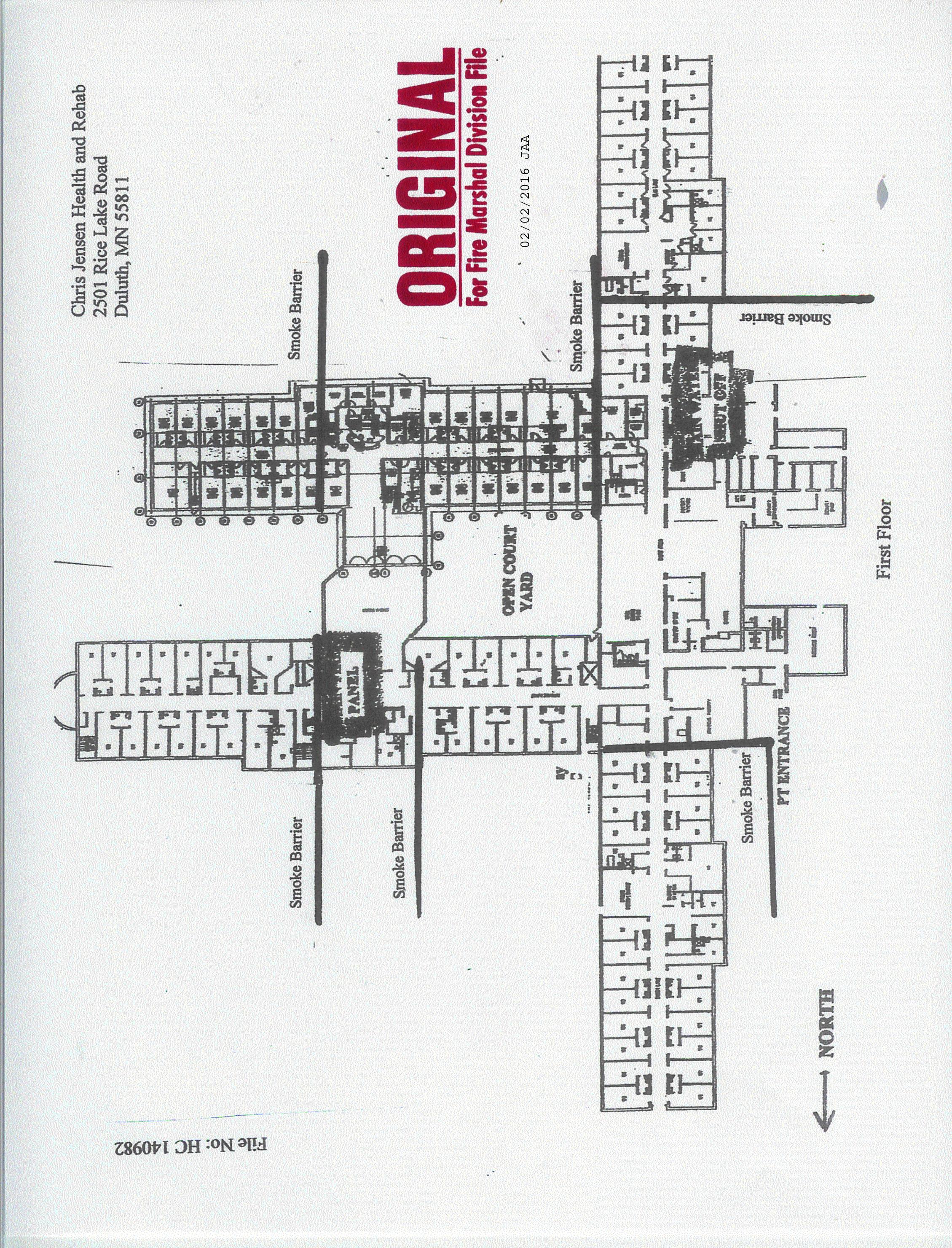
## PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

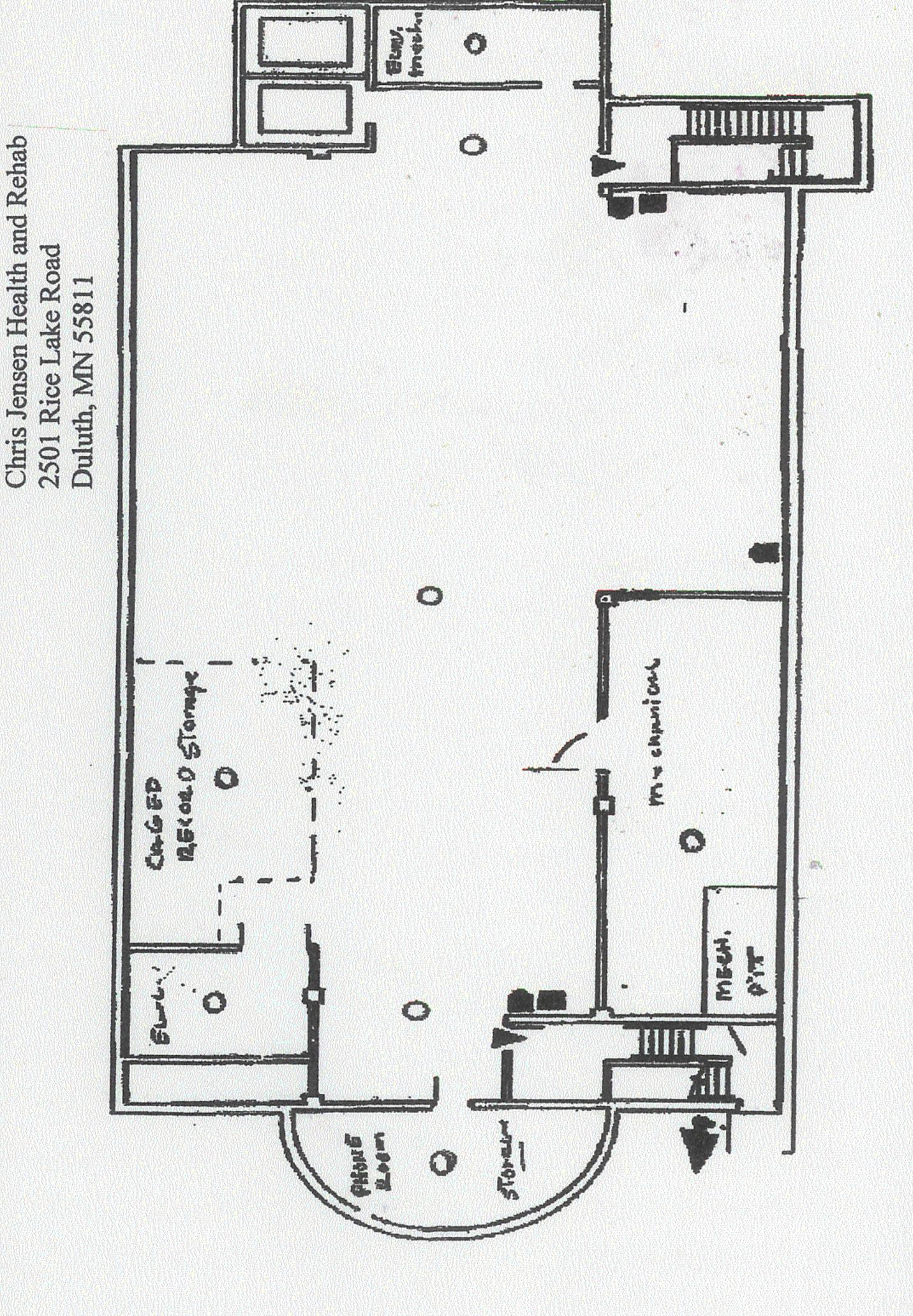
For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION	JUSTIFICATION		
K400				

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature)	Title	Office	Date

Minnesota	State Fire Mars	hal Division-CMS Survey Draft Statemen	nt of Deficiencies	Page of		
PROJEC	T NUMBER:	PROVIDER NAME		SURVEY DATE		
Adminis	strator:	I.	Phone Numb	DÈT:		
Email ac	ddress:					
State Fir	re Inspector:					
These ar		findings only. A complete and final S	Statement of Deficiencies	2567 report will be provided		
Satin t						
K TAG S& S		Summary of Deficiency(ies)	Revisit	☐ Clearance		







02/02/2016 JAA