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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 55P9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00598

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245366**

2.STATE VENDOR OR MEDICAID NO.
(L2) **175040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **CHRIS JENSEN HEALTH & REHABILITATION CENTER**
(L4) **2501 RICE LAKE ROAD**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2009**

6. DATE OF SURVEY **10/22/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC 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 The Following Requirements:
___ 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
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	170			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 11/02/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 11/02/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

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 APPROVAL

DEPARTMENT OF HEALTH

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

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 https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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

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 MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 55P9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00598

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245366**

2.STATE VENDOR OR MEDICAID NO.
(L2) **175040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **CHRIS JENSEN HEALTH & REHABILITATION CENTER**
(L4) **2501 RICE LAKE ROAD**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2009**

6. DATE OF SURVEY **08/23/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC 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:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 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
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	170			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HFE - NE II 09/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/02/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - 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;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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: 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
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St. Paul, Minnesota 55101-5145
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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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	08/23/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/20/18, to 8/23/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		10/2/18

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

Electronically Signed | 09/20/2018

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F 623	Continued From page 1 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in	F 623		

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F 623	Continued From page 2 completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §	F 623		

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F 623	Continued From page 3 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the ombudsman of a facility initiated transfer for 1 of 6 residents (R94) reviewed for hospitalization. Findings include: R94's admission Minimum Data Set (MDS) dated 7/2/18, indicated diagnoses which included septicemia, paraplegia and neurogenic bladder. R94's MDS also indicated R94 had admitted to the facility from the hospital on 6/23/28, and on the same day R94 was discharged back to the hospital. On 6/23/18, R94's progress note indicated R94 was admitted to the facility from the hospital. The note further indicated R94 had a temperature of 102.1 Fahrenheit (F) and the nurse had called the provider at the hospital who gave an order to send R94 back to the hospital if R94 spiked another temperature. The progress note further indicated at 11:30 p.m. R94's temperature was 101.7 F, and R94 was sent back to the hospital at midnight. On 6/25/18, R94's progress note indicated R94 was re-admitted to the facility on 6/25/18, with admitting diagnosis of sepsis, and an order for intravenous (IV) antibiotic. On 8/22/18, at 10:18 a.m. the director of social service SS-A verified R94 had been discharged to the hospital on 6/23/18, and returned 6/25/18. SS-A verified she had not notified the ombudsman of R94's discharge to the hospital.	F 623	F623 □ Notice Requirements Before Transfer/Discharge: " The Ombudsman has been notified of the facility initiated transfer to the hospital that occurred on 6/23/18 for Resident #94. The resident was readmitted to Chris Jensen from the hospital stay on 6/25/18 and remains a resident at Chris Jensen. " The Ombudsman is notified of other residents who have facility initiated transfers to the hospital at least monthly. " The format for communicating the hospital transfers has been reviewed and revised. " Nursing staff are completing the hospital discharge/transfer notice. " Social service is responsible to send a copy of the hospital discharge/transfer notices to the ombudsman. " Monthly audits of all residents transferred out to the hospital to ensure that the ombudsman has been notified, will be conducted by Social Services.	

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F 623	Continued From page 4 On 8/22/18, at 2:20 p.m. the regional ombudsman verified she had not been notified of R94's discharge to the hospital. A policy on notification of the ombudsman was requested but not provided.	F 623		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to	F 640		10/2/18

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F 640	Continued From page 5 the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Death in Facility Minimum Data Set (MDS) assessment was submitted for 1 of 2 residents (R1) reviewed for resident assessment. Findings include: R1's Admission Record printed 8/23/18, indicated diagnoses that included dementia, chronic kidney disease, and atrial fibrillation. On 4/28/18, R1's progress note indicated R1 had died in the facility on 4/28/18. Review of R1's medical record lacked a Death in Facility MDS. On 8/22/18, at 1:17 p.m. registered nurse (RN)-A (the MDS coordinator) verified R1 had died in the	F 640	F640 □ Resident Assessments: " The Death in Facility MDS assessment was completed for R1 and has been submitted and accepted. " All residents MDS's have been reviewed for timely transmission. " The system for timely completion and submission of MDS assessments has been reviewed and revised for all residents. " MDS coordinators have been re-educated regarding facility expectations for timely completion of MDS assessments to include the Death in	

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F 640	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."	F 640	Facility MDS when applicable. " Audits of timely MDS assessment, completion and submission/transmission will be conducted by the MDS Director two audits weekly x 4 weeks, then one audit monthly x two months or as directed by QAPI.	
F 641 SS=D	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. Findings include:	F 641	F641 □ Accuracy of Assessments: " Quarterly MDS dated 6/7/18 for R31 has been corrected to include documentation of Stage 3 Pressure ulcer, and unstageable pressure ulcer with suspected deep tissue injury in accordance with the wound	10/2/18

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F 641	Continued From page 7 R31's Admission Record printed 8/23/18, indicated R31 had diagnoses that included paraplegia (paralysis), unstable burst fracture of T7-T10 (thoracic area of the spine), and epilepsy. R31's quarterly MDS dated 6/7/18, indicated R31 required total assistance with all activities of daily living (ADLs) except eating. The MDS lacked documentation of a Stage three pressure ulcer or an unstageable pressure ulcer with suspected deep tissue injury R31's Wound Documentation notes indicated R31 had a suspected deep tissue injury on the left heel since 10/12/17, and a Stage 3 pressure area on the coccyx/sacrum since 12/29/17. On 8/23/18, at 11:33 a.m. licensed practical nurse (LPN)-E and registered nurse (RN)-A both verified R31's MDS was inaccurate. R32's Admission Record printed 8/23/18, indicated R32 had diagnoses that included chronic kidney disease, heart failure, and type 2 diabetes. R32's electronic medication administration record (eMAR) dated June 2018, indicated insulin was discontinued on 6/1/18. R32's significant change MDS dated 6/8/18, indicated R32 had received insulin 7 times in the past 7 days. On 8/23/18, at 8:54 a.m. licensed practical nurse (LPN)-E indicated she must have looked at the eMAR, and missed the discontinued date for the insulin. LPN-E indicated the MDS would need to	F 641	documentation notes. " Significant change MDS dated 6/8/18 has been corrected to reflect the discontinuation of insulin that occurred on 6/1/18. " MDS for other residents have been reviewed to ensure the accuracy of coding on the MDS " MDS coordinators have been re-educated regarding facility expectations for accuracy with MDS to include pressure ulcer and medication use information. " Audits of MDS assessments will be completed to monitor accuracy. These audits will be conducted by the MDS coordinators two audits weekly X4, then two audits monthly or as directed by QAPI.	

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F 641	Continued From page 8 be changed.	F 641		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use was maintained during wound care for 1 of 3 residents (R15) observed during wound care. In addition, the facility failed to ensure daily wound care was documented and wound staging was accurate for R15's wounds. Findings include: R15's quarterly Minimum Data Set (MDS) dated 5/25/18, indicated diagnoses that included paraplegia, pressure ulcer of the left buttock, pressure ulcer of the coccyx, and local skin infection of the skin and subcutaneous tissue. In addition, the MDS indicated R15 had two Stage 4 pressure ulcers (Full-thickness skin and tissue loss with exposed or directly palpable fascia,	F 686	F686 □ Pressure Ulcers: " Resident 15 was discharged from Chris Jensen on 8/24/18 as previously planned. " Other residents with pressure ulcers have been reviewed to ensure accuracy with staging. These residents are receiving treatments as ordered by the physician. The treatments are done using proper hand hygiene and glove use. " Nurse managers have received re-education on appropriate staging of pressure ulcers. " Licensed nurses have been re-educated regarding facility expectations for providing treatments as ordered by the	10/2/18

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F 686	Continued From page 9 muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole [rolled edges], undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury). The MDS also indicated R15 received pressure ulcer care, had intact cognition, and did not reject cares. R15's care plan dated 9/21/17, indicated R15 had Stage 4 healing pressure ulcers on admission, with Methicillin-resistant Staphylococcus aureus infection (MRSA; a type of staph bacteria that is resistant to many antibiotics) and received wound dressing changes. The care plan directed staff to monitor and document the wound size, appearance, and to stage the wounds. In addition, the care plan directed staff to follow the facility policies/protocols for the prevention/treatment of skin breakdown and administer treatments as ordered. On 8/22/18, at 11:01 a.m. R15 stated he had concerns his wound care was not being done twice daily as ordered. R15 stated wound care had not been done the previous evening shift on 8/21/18. R15 stated he had not refused the nurse to do it, and stated it was not even offered. R15 further stated at times, the nurses did not do it twice a day. On 8/23/18, at 8:13 a.m. registered nurse (RN)-B was observed to provide wound care for R15's two pressure ulcers on the coccyx and the left buttock areas. RN-B stated to R15 she was going to do the wound care. RN-B went to the bathroom and washed her hands, half filled an emesis basin with warm soapy water, half filled a wash	F 686	physician, and documenting any exceptions along with reason why and attempts if the resident is refusing the treatment. " Licensed nurses have been re-educated regarding facility expectations for proper hand hygiene and glove use to be maintained during wound care. " Audits to monitor completion of pressure ulcer treatments and audits of documentation as ordered by the physician will be completed by the Nurse Manager two audits weekly x 4, then two audits every other week x 2, and then as directed by the QAPI. " Observational audits of proper hand hygiene and glove use during wound care will be conducted by Nurse Managers two audits weekly x 4, then two audits every other week x 2, and then as directed by QAPI.	

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F 686	Continued From page 10	F 686		

basin with plain water, and set both basins on the bedside table. RN-B took an empty wash basin and set it to the right of the wash basin with plain water. RN-B donned a clean gown. RN-B stated R15 had history of MRSA infection in the wound beds. RN-B applied gloves, and removed a soiled dressing around R15's suprapubic stoma site. RN-B picked up a bottle of wound cleanser, and sprayed the area twice. RN-B used gauze to wipe the area, and used an alcohol wipe to clean the skin and catheter tube, and tossed the wipe in the garbage. RN-B removed her gloves and without performing hand hygiene, reached into the closet (which contained the wound supplies) and took out 4 centimeter (cm) by 4 cm gauze. Without performing hand hygiene, RN-B donned clean gloves, opened the gauze wrap, applied the clean gauze dressing around R15's stoma site, and taped it down. RN-B removed her soiled gloves, asked R15 to turn to the left side, and without performing hand hygiene, donned a clean pair of gloves. RN-B reached into the packet of gauze, took a handful of gauze, and dropped them into the plain water basin. RN-B grabbed another handful of gauze and placed them into the empty basin. RN-B reached into the box with Normal Saline (NS) solution and grabbed one tube, opened the cap, and squeezed the solution on the gauze in the empty basin. RN-B cleansed both wounds with the soapy water, then reached into the basin with gauze soaked in plain water, and obtained multiple gauze pads which she used to cleanse the wounds. RN-B reached into the dry gauze packet, grabbed several pieces of gauze, and used them to dry both pressure ulcers. RN-B did not change gloves or perform hand hygiene while doing the wound care on both pressure ulcers. RN-B reached into the third basin which had multiple gauze soaked in Normal Saline

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solution, and used these to start packing the wound. Before covering the wounds with a dressing, the surveyor intervened and asked RN-B to remove the soiled gloves as she had used them to clean the wounds. RN-B removed the soiled gloves, and reached for clean gloves. Without performing hand hygiene, RN-B started applying clean gloves. Again the surveyor intervened, and asked RN-B to wash her hands before donning clean gloves. RN-B proceeded to pack both pressure ulcers with multiple gauzes moistened with Normal Saline solution, applied ABD dressings on top of the pressure ulcers, and taped the dressings to the skin. RN-B removed her gown and gloves, tossed them in the garbage, and without performing hand hygiene, applied clean of gloves. RN-B moistened two pieces of gauze with the wound cleanser, cleansed an open area on R15's left great toe, and patted the area dry. RN-B picked up the basins with soapy water and plain water, brought 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.

Review of R15's daily wound treatment documentation, indicated the following:
8/14/18: Evening shift, no wound care completed. A note indicated R15 was out of the facility.
8/15/18: Day shift, no wound care completed.
8/16/18: Day shift, no wound care completed.
8/21/18: Evening shift, no wound care completed. A progress note indicated R15 was sleeping when the nurse approached him.
8/22/18: Evening shift, no wound care completed. A note indicated R15 refused.

On 8/23/18, at 9:08 a.m. licensed practical nurse

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(LPN)-B verified R15 was not out of the facility on 8/14/18. LPN-B verified wound care had not been documented as completed on 8/14/18, 8/15/18, and 8/16/18. LPN-B stated the nurses were expected to write a note to explain why it was not completed. LPN-B stated on 8/15/18, R15 had an appointment at 9:00 a.m. with pick up 8:00 a.m. however, LPN-B was not sure when R15 had returned to the facility, and there was no documentation that wound care had been offered or attempted to be completed after the appointment. LPN-B stated R15 had no medical appointment on 8/16/18, and there was no documentation to explain why wound cares were not completed. LPN-B stated he would expect the nurses to reapproach R15 if wound care was refused or not completed, and all the nurses were to document attempts in the medical record. LPN-B also verified on 8/21/18, and 8/22/18, nurses should have communicated to the next nurse to approach R15 to do the wound care as ordered. LPN-B stated R15 had a history of MRSA in the pressure ulcers. and he would expect the staff to follow standard infection control protocol for wound care, glove use and hand hygiene to prevent infections to the wounds. LPN-B further stated RN-B was supposed to use separate gloves for each of the pressure ulcers when cleaning them, and was to remove the soiled gloves, wash hands, and apply a clean pair of gloves before packing the wounds and applying the clean ABD dressing.

On 8/23/18, at 9:21 a.m. the director of nursing (DON) stated she would expect RN-B to have completed wound care following proper infection control procedures. The DON also stated staff nurses were to document wound care, and expected them to reapproach R15 to complete

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F 686	Continued From page 13 wound care. . On 8/23/18, at 10:06 a.m. RN-B stated R15's wound care was not intended to be a sterile procedure. RN-B stated if it was a sterile procedure, she would have removed her gloves, washed her hands, and proceeded with the wound care. RN-B stated this was not the case, and this was how she understood she was to complete the wound care. RN-B verified she had not washed her hands and removed gloves as required on multiple times when completing wound care. RN-B acknowledged R15 was at risk for developing infections, and she stated she had completed the wound care as taught. The facility Pressure Injury/Skin Integrity/Wound Management policy revised 11/16, directed the licensed nurses to daily and/or routinely document the residents skin condition, the response to care and treatment to the skin. The facility Hand Washing policy dated 4/1/08, directed staff to scrub their hands with soap and water thoroughly for 20 seconds, and staff were to wash fingers and nails. The facility Gloves, Non-Sterile policy dated 4/1/08, directed staff, while wearing gloves, to avoid handling personal items to prevent contamination; staff were also to remove gloves that were contaminated as soon as possible, and staff were to wash their hands upon removal of the gloves.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		10/2/18

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F 689	Continued From page 14 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement identified interventions to reduce the risk for falls for 2 of 6 residents (R95, R13). In addition, the facility failed to conduct ongoing comprehensive assessment of falls to determine causal factors to reduce the risk for falls for 3 of 6 residents (R95, R147, R26) reviewed for accidents. Findings include: R95's annual Minimum Data Set (MDS) dated 7/25/18, indicated diagnoses that included dementia, Parkinson's disease and diabetes. The MDS also indicated R95 was severely cognitively impaired, required extensive assistance for all activities of daily living (ADLs) and was frequently incontinent of bowel and bladder. R95's care plan identified a risk for falls related to confusion and balance problems, and indicated R95 was unaware of safety needs. On 8/22/18, R95 was continuously observed from 7:05 a.m. until 8:33 a.m. At 7:05 a.m. R95 was observed sitting in his wheelchair, self-propelling around the dining room. At 7:12 a.m. R95 was in front of the nurse's station desk requesting to call his brother. Licensed practical nurse (LPN)-B told R95 to give him a little bit, and he would find the number for him. R95 was observed to have a	F 689	F689 □ Accidents: " Resident 95 no longer resides at Chris Jensen. " Identified fall intervention risks have been reviewed, revised if indicated and implemented for R13. " A comprehensive assessment of falls to determine causal factors to reduce the risk of falls has been completed and is ongoing for R147 and R26. " Other residents with falls are assessed to determine causal factors to reduce risk of falls. Resident centered interventions are determined and implemented with ongoing review if falls continue to occur. " Falls are reviewed by the IDT for recommendations. Residents with multiple falls include a review of the fall history, multiple fall causal factors, current interventions and resident centered approach to falls. " Nursing staff have been re-educated regarding facility expectations for fall prevention and response. " Audits of care plan interventions and observation of implementation will be completed by Nurse Manager two audits weekly x4, then two audits every other week x2, then as directed by QAPI.	

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fading yellow bruise on his forehead. R95 started propelling himself down the hallway. A staff member pushed him back into the dining room, where a television was on to a talk show. R95 was propelling himself in the dining room. At 7:46 a.m. R95 attempted to exit the unit via an open elevator door, registered nurse (RN)-B intervened and told R95 he needed his hearing aids. R95 asked RN-B who she was and called her a name. R95 was again escorted back to a table in the dining room by a staff member, but was not offered anything to eat or drink. A linen napkin and a box of tissues were on the table. R95 began emptying the box of tissues onto the table. R95 then propelled himself away from the dining room table. At this time, a radio was playing a country station, and three other men were sitting at the table, but no one was talking. Three other residents were sitting in the dining room with their eyes closed, a fourth resident was sitting in a wheel chair with her hands covering her face, and another resident sat alone at a table with her arms crossed in front of her. There was no attempt by staff to engage R95 or the other residents during the observation. At 8:18 a.m. R95 made another attempt to exit the unit through the elevator door. Staff again intervened, and did not allow him to leave. R95 pushed the elevator button again, and a staff member brought him back to his table in the dining room and walked away. R95 propelled away from the table and headed back to the elevator. At 8:25 a.m. the elevator door opened, and R95 attempted to exit but his wheel chair was stuck on the wall preventing him from moving. At 8:27 a.m. the elevator door opened again, and R95 again attempted to get in. A staff member brought him back to the table in the dining room. At 8:33 a.m. R95 threw a napkin on the floor. A resident

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seated at the table picked up the napkin and gave it to R95. R95 threw the napkin under the table a second time and attempted to stand up out of the wheel chair to pick it up. While trying to kneel on the floor, R95 fell onto his right side on the floor. LPN-C responded to the fall and stated to R95, "You did that on purpose didn't you?" LPN -C then stated to another staff member, "He so did that on purpose." LPN-C then turned to R95 and again asked him why he put himself on the floor. R95 remained lying on the floor. LPN-C stated to R95, "You threw yourself on the floor, why did you do that?" At this time, R95 remained on the floor with five staff members standing over him. R95 displayed signs of agitation. R95 attempted to hit staff and squeezed LPN-C's hand, pointed at her with the other hand and stated, "It was you." The certified nurse practitioner walked over to where R95 was lying, and asked what happened. LPN-C stated R95 put himself on the floor, and stated he had been wild all night, throwing things and trying to punch staff. During the observation there were no attempts by staff to offer R95 fluids, food, toileting or any staff or activity engagement.

A review of facility documents identified the following:

A Resident Incident Report dated 7/30/18, indicated R95 was holding onto a fire door bar, stood up and slid to the floor. The report indicated R95 had numerous falls, and had impulse control issues. An interdisciplinary team (IDT) Root Cause Review dated 8/1/18, indicated a walking program to help with impulse control was initiated, and R95 was to be moved closer to the nurses station when a room became available.

A Resident Incident Report dated 7/31/18,

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indicated R95 was found sitting on his fall mat with his arm and elbow still on the bed on pressure pad alarm. The report indicated an extensive fall history, impulse control, and poor judgement. An IDT Root Cause Review dated 8/1/18, indicated consider walking program to see if it helps.

A Resident Incident Report dated 8/3/18, indicated R95 was found on the floor mat sitting on his buttocks and leaning on his left side against the bed. The report indicated a tabs alarm was placed, and indicated R95 had a history of manipulating alarms. An IDT Root Cause Review indicated R95's pressure alarm was removed, and replaced with a tab alarm.

A Resident Incident Report dated 8/8/18, indicated R95 was attempting to sit up from his wheelchair, and another resident attempted to assist, causing R95 to fall. An IDT Root Cause Review dated 8/10/18, indicated occupation therapy to screen for wheelchair positioning, and a need for new anti-rollbacks for wheel chair.

A progress note dated 8/11/18, indicated R95 was witnessed putting himself on the floor beside his wheel chair.

A Falls Risk Post - Fall Assessment dated 8/14/18, indicated R95 was at the nurse's station and sustained a fall. An IDT Root Cause Review dated 8/14/18, indicated the facility was currently working on medication review with R95's provider, and discussed discontinuation of Seroquel.

A progress note dated 8/15/18, indicated R95 was wide awake, was put back to bed, but tried

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numerous times to throw himself out of bed. When staff attempted to reposition R95, he was hitting, kicking, and punching.

A progress note dated 8/21/18, indicated R95 was aggressive on night shift, and tried to put himself on the floor. R95 was lowered to the floor safely by staff.

A progress note dated 8/22/18, indicated staff witnessed R95 stand up from his wheel chair and lay himself down on the floor. R15's incontinence brief was noted to be wet at the time. R95 sustained an abrasion measuring 4 centimeters (cm) x 1.5 centimeters to his middle back from rolling himself around on the floor.

A Resident Incident Report dated 8/22/18, indicated R95 fell while sitting in the dining room in his wheelchair with his tabs alarm on. A correlating progress note dated 8/22/18, indicated R95 was propelling himself all over the dining room, and put himself on the floor to "get attention."

On 8/23/18, at 9:49 a.m. nursing assistant (NA)-B stated R95 would put himself on the floor and stated staff keep him by the nurses station because he will "pop" himself out of bed and onto the floor. NA-B stated she did not know if R95 comprehended what staff were saying or not, but stated R95 could understand simple cues. NA-B stated if staff asked R95 what he wanted he could sometimes tell them. NA-B stated staff put R95 by the nurse's station, but he got mad when staff kept him there, and that would lead to behaviors.

On 8/23/18, at 10:15 a.m. LPN-D stated the last couple of times she worked R95 tried to push

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himself out of his chair. LPN-D stated R95 would roll out of bed. LPN-D stated R95 thought he was in jail at the facility, and did not understand he was there to stay. LPN-D stated R95 would say nobody was paying attention to him.

On 8/23/18, at 10:33 a.m. LPN-B stated after a fall occurs, the nurse will come up with a short term intervention, then he would review the information and review what was done in the past. LPN-B stated falls were discussed in an IDT meeting, and the team discussed what was working on other units, discussed interventions, and initiated or changed interventions. LPN-B stated R95 had a significant history of falls, and there were numerous interventions in place.

During an interview on 8/23/18, at 11:01 a.m. family member (FM)-A stated R95 told him he has laid in bed for hours and no one would show up. FM-A stated falling was how R95 got them to pay attention.

During a subsequent interview on 8/23/18, at 2:02 p.m. R95's falls were reviewed with LPN-B. LPN-B stated the intervention on 7/24/18, was to continue with the current intervention of an alarm. Regarding the falls on 7/30/18, and 7/31/18, LPN-B stated there was no documentation to indicate whether or not the walking program implemented as an interventions was being attempted by staff, and he did not know if they were doing it. LPN-B stated the occupational therapy assessment initiated following the fall on 8/14/18, (in which another resident was attempting to assist R95 to stand) was due to a need for new anti-rollbacks for the wheel chair. In regards to the 8/14/18, intervention which indicated the provider was to review R95's

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Seroquel, LPN-B stated the Seroquel order had not been adjusted until 8/22/18, and was discontinued when R95 admitted to hospice.

R13's annual MDS dated 5/24/18, indicated diagnoses that included dementia, and diabetes. The MDS further identified R13 was severely cognitively impaired, required extensive assistance with ADLs, and was frequently incontinent of bowel and bladder.

R13's care plan dated 5/24/18, identified a risk for falls related to dementia, bowel and bladder incontinence, and behaviors with impulsiveness. The care plan directed staff to use gripper socks in bed, keep the bed at a seated height, and re-direct when agitated. The care plan also identified the use of a scoop mattress, offers to get up on overnight last rounds, and anti-skid mattress at bed side. Further, the care plan indicated staff to assist with toileting, but did not identify a frequency.

On 8/22/18, at 7:51 a.m. R13 was observed sitting in her wheelchair. R13 had auto locking brakes on her wheelchair, and was propelling herself up and down the halls on the unit.

Review of facility documents identified the following falls:

A Resident Incident Report dated 5/17/18, indicated R13 was found on the floor in the doorway of her room. The report indicated a history of falls. An IDT Root Cause Review dated 5/21/18, indicated staff were to offer to get R13 up after nap during the day.

A Resident Incident Report dated 6/4/18,

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indicated R13 was found sitting up next to her bed. An IDT Root Cause Review dated 6/6/18, indicated staff were to offer to get R13 up at 7:00 a.m.

A Resident Incident Report dated 6/30/18, indicated R13 was found sitting against her bed on the floor. An IDT Root Cause Review dated 7/2/18, indicated staff were to check on R13 at last overnight rounds, and offer to get her up.

A Resident Incident Report dated 8/8/18, indicated R13 was found sitting on her bed and slid off as staff approached, landing on the floor. A IDT Root Cause Review dated 8/8/18, indicated an anti-skid mattress was placed on the floor next to R13's bed.

A Resident Incident Report dated 8/11/18, indicated R13 was found sitting next to her bed supporting herself with one arm. An IDT Root Cause Review dated 8/13/18, indicated a six day sleep study was to be implemented.

On 8/23/18, at 1:27 p.m. LPN-B stated a sleep study was initiated on 8/13/18, to determine a pattern for R13 however, the sleep study was not completed by staff. LPN-B further stated there had been no follow-up with the night shift to determine if R13 was getting up on the overnight shift or not.

On 8/23/18, at 2:56 p.m. the director of nursing (DON) stated the IDT met every Monday to discuss falls. The DON stated the IDT discussed the time of day the falls occurred, whether the resident was hungry, thirsty or if they needed to use the bathroom. The DON stated the team also discussed effectiveness of the interventions, and

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if changes were needed. The DON stated the nurse manager was responsible for following up on fall interventions.
R147's Admission Record printed 8/23/18, identified R147's diagnoses included dementia, difficulty in walking, tremor, and repeated falls.
R147's admission MDS dated 1/4/18, indicated R147 had severe cognitive loss, received psychoactive medications, was frequently incontinent of urine, and required extensive assist with toileting. The MDS further identified R147 had falls with injury prior to admission, but no falls since admission.
R147's ADLs care plan dated 1/8/18, indicated R147 required extensive assistance of 1-2 staff with a walker for ambulation. A hand written note on the care plan dated 1/25/18, indicated R147 refused assistance with ambulation, or to use walker. A 2/13/18, hand written note indicated R147 was independent on the unit, and was to toilet upon rising, before and after meals, bedtime and as needed. Staff were directed to offer to toilet R147 every four hours on the night shift. A hand written note dated 6/8/18, directed staff to offer rest period with fluids and snacks. An 8/6/18, hand written note directed staff to offer to lay down after lunch. An 8/9/18, hand written note indicated no ambulation, transfer with assist of 1-2, stand pivot weight bearing as tolerated.
R147's Safety/Falls care plan dated 1/8/12, directed use of a wheelchair, call light in easy access, check for unmet toileting needs, pain, etc., ensure environment is free from clutter, fall review facility protocol, reinforce need to use the call light to request assistance, and secure or locked placement. On 1/30/18, hand written note indicated nonskid footwear (gripper socks) were added. On 2/7/18, a note directed to offer to lay down after lunch. A note dated 2/13/18, indicated

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resident frequently noncompliant with offered rest periods. On 3/6/18, a hand written note indicated to redirect to sit down in dining room as resident allows, offer rest period with sweets. On 8/6/18, a hand written note indicated place abduction wedge between resident's legs at meal times as tolerated. On 8/8/18, a hand written note indicated a pad alarm to wheelchair.
Review of the R147's progress notes indicated the following falls:
On 1/26/18, at 12:46 a.m. Found crawling on hands and knees on the floor in the doorway to her room. Had been toileted and helped into bed at 11:00 p.m. Stated her knee gave out. No red areas noted, no swelling or obvious deformities. Very pleasant and cooperative. Confused conversation per normal but was smiling. Assisted up and walked to bed, denied having to use bathroom first, but then said she had to go. Assisted to toileting.
On 1/27/18, at 6:13 p.m. Resident had witnessed fall at 5:40 p.m. in hallway. Resident walking unsteady and agitated. Would not allow staff to assist in any way. Resident angry and carrying a knife. Resident fell onto left side and would not allow any assistance or vitals to be taken. Resident immediately stood up on own and began walking again; did not hit head. Knife fell out of resident's hand and was quickly removed from area by staff. Writer spoke with husband to notify of fall and agitation
On 1/29/18, at 3:33 p.m. Resident had a witnessed fall on a.m. shift at approximately 1:25 p.m., she was walking backwards and fell with her back landing into another residents wheelchair. She then refused to have any vitals done, was having aggressive behaviors. Then got up off the floor with minimal help from staff, refused help. Sat in her w/c for a while, and then

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moved into one of the dining hall chairs and has been sitting there. As she was sitting there she was saying aggressive things towards staff, and other residents. No complaint of pain, did have Tylenol at approximately 1:40 p.m. Will continue to monitor for injury, but no apparent injury at this time.
On 2/25/18, at 11:50 a.m. Resident found sitting on buttocks on the floor in the dining room with the back against the wall in between two chairs, a tray table was located in front of the chair to the left of the resident. When asked what happened, the resident stated, "I tried to sit down on the table and I sat down on the floor." Fall was unwitnessed, neurological assessments started and remained at resident's baseline. Resident did complain of a slight discomfort in left forearm area, no injury/redness/bruising noted. The pain went away within 5 minutes, resident stating, "I took my medications this morning." Resident moves all extremities without any pain or guarding. No injuries noted. Care plan followed, nonskid footwear on, resident last toileted 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 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 started on Risperidone 0.25 milligrams (mg) mg twice a day on 1/24/18. Then Risperidone was increased to

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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 and was also treated for a urinary tract infection. It is also noted that since the start of Risperidone, resident had had 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 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 was pushed by another resident into the wall hitting her head and falling to the floor. Observed by staff who reported that she noticed that resident "was not responsive for a minute." This writer responded immediately as a large noise was heard from incident. Resident was found lying on her right side in the hallway, but was responsive to staff when this writer approached resident. 5 x 5 centimeter (cm) bump observed on the right side of resident head. No other injuries observed. Neuro checks started per policy. Some initial mild weakness in extremities noticed, but 15 minutes later resumed to baseline. Resident assisted up off the floor two times, and walked down to the dining room. Ice pack was applied to resident head for 20 minutes. Denies any pain. Resident able to follow commands and ate a good dinner. DON [director of nursing], RN [registered nurse] manager, on-call provider and family notified of incident. No

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new orders. Will continue to monitor for signs and symptoms of concussion or injury. Resident was later observed to walking around the unit socializing with staff and other resident appropriately.
On 4/22/18, at 2:20 p.m. Patient was ambulating in dining area and fell backwards due to a push from another resident. No apparent injury and patient. Resident didn't hit her head, this was a witnessed fall. Writer spoke to Chris Jensen manager on call and patient's husband in regards to incident. Faxed incident report left in Doctors rounding book. Neuro status intact-will continue to observe. On 4/27/18, haloperidol (Haldol, an antipsychotic medication) was discontinued to see if it was causing/contributing to falls.
On 5/8/18, 11:00 a.m. Falls Risk Post Fall Assessment indicated the following. R147 had a fall that occurred in end lounge room. Wearing nonskid footwear, underlying diseases or conditions: psychiatric or cognitive conditions, orthopedic/joint/arthritis, seizures. Takes psychotropic, anti-seizures. Functional status: unsteady at times, receiving rehab, occasional incontinence of bladder, self-toilets at times. Dementia. Was pushed by another resident.
On 5/8/18, at 11:00 a.m. an IDT Root Cause note indicated R147 was in lounge, and another resident pushed resident to floor, and she landed on her side. Resident did not hit head, and no injury at time of incident. Fall was witnessed by visitors. Causative factors: repeated falls, muscle weakness, disorientation unspecified. IDT determined root cause of fall to be pushed by another resident.
On 6/7/18, at 6:08 p.m. Kitchen staff found resident lying on floor. Staff intervention: assessment, neuro checks, moved all extremities, complaint of pain directly above left

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breast and below left breast. No injuries noted. Call to family/MD with notification.
On 6/7/18, at 5:15 p.m. a Falls Risk Post Fall Assessment: Fall indicated R147 had an unwitnessed fall, prior to ambulating in hall. Current interventions: safety monitoring, encourage resident to rest. Psychiatric or cognitive issues: use of psychotropic medication and anti-seizure medication. Functional status: leans to right when tired and ambulating. IDT Root Cause 6/8/18, for fall on 6/7/18, at 5:15 p.m. Resident found on floor in dining room. Causative factors: weakness/unsteady gait, dementia. IDT determined root cause of fall to be: ambulating on unit. New/Different period interventions now in place related to root cause: offer rest period with fluids and snacks. On 6/15/18, R147's psychiatrist notes indicated, "Major neurocognitive disorders due to known physiological condition, history of traumatic brain injury at age of 5, progressive cognitive decline likely Alzheimer's. Now with physical aggression and agitation along with delusional statements and thoughts. Milk [sic] increase in agitation now resolved, controlled. Anxiety disorder, psychotic disorder with delusions, and significant paranoia causing agitation and aggression. 'Well controlled with current therapy.' High risk medication use on psychotropic, monitoring weight, screening for movement issues on a monthly basis. Monitoring for sedation and falls benefits of anti-psychotic medication currently out weight risks. Will reevaluate medications on a monthly basis and attempt taper as appropriate."
On 6/28/18, at 6:46 Writer notified by TMA [trained medication aide] that resident had a fall at 12:30 a.m. in bathroom doorway, sitting up on buttocks trying to get up. Noted red spot above upper left eyebrow. Fall unwitnessed. Resident

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unable to tell nurse what she was trying to do prior to event due to poor cognition. Doctor on call notified regarding injury to head. Resident in no acute pain and helped back into bed with Neuro's and vital signs started. Day nurse to notify family and manager. A Falls Risk Post Fall Assessment: for the fall 6/28/18, at 12:30 a.m. indicated R147 was in the bathroom, trying to use bathroom. Injury: red mark. Fall interventions currently being used. Gripper socks, bed low position, frequent vital signs, toilet. Underlying causes: psychiatric or cognitive, seizures/tremors, medications Psychotropic, anti-seizures, functional status: mobility issues, cognitive issues. Resident found in bathroom doorway sitting on butt, trying to get up. No apparent injury, six day bowel and bladder study.
On 6/28/18, IDT Root Cause for the fall on 6/28/18, at 12:30 a.m. indicated resident found in bathroom door way sitting on butt, trying to get up. No apparent injury. Unsteady gait, disorientation, repeated falls. IDT determined root cause to be: wanting to use the toilet.
New/different interventions now in place related to 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.

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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. R147 returned to the facility on 7/31/18. On 8/2/18, at 11:10 p.m. Resident had unwitnessed fall in bedroom next to bed on 8/2/18, at 3:30 p.m. Resident was attempting to transfer self to bed. Resident had been toileted about five minutes prior. Surgical incisions appeared intact and resident was able to move right hip joint with no signs of pain or impingement. Neuro checks started per policy due to fall being unwitnessed. Physician notified and attempted to notify family (unable to leave message as there is no answering machine). Will pass to next shift. A Falls Risk Post Fall Assessment dated 8/6/18, for fall 8/2/18, at 15:30-fall occurred in bedroom, attempting to transfer self to bed. No injury current fall intervention Low bed, 3 or more falls in the past six months: underlying conditions psychiatric, orthopedic/joint/arthritis. psychotropic medications, anti-seizures, antihistamines.

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Functional Status: unsteady gait, wheelchair, No safety awareness, not able to communicate needs, change in pain level (recent fractured hip). Resident attempting to self-transfer. 15 minute safety checks and continue low bed. On 8/6/18, the IDT Root Cause Review (for fall 8/2/18 at 15:30 p.m.) indicated: Prior to fall resident had unwitnessed fall in bedroom next to bed. Review of causative factors: unsteady gait/muscle weakness. IDT determined root cause of fall to be: Self transfer to her bed. New/different interventions now in place related to Root Cause: offer to lay down after lunch.
The Fall Log, recorded by individual resident indicated R147 had 18 falls:
1/22/18, in the dining room with no injury at 6 p.m. the intervention was 3 sleep observation and 3 day bowel and bladder tracking.
1/25/18, in bedroom with no injury at 11:30 p.m. the intervention was PT [physical therapy] to screen, x-ray right foot/ankle.
1/27/18, in hallway with no injury at 5:40 p.m. the intervention was medical workup and pain management.
1/29/18, in hallway with no injury at 1:25 p.m. the intervention was no skid footwear, new fall risk assessment.
2/5/18, in dining room with no injury at 6:50 p.m. the intervention was to offer and encourage rest in bed after lunch.
2/10/18, in dining room with no injury at 11:20 a.m. intervention was continue to offer rest periods.
2/23/18, in dining room with no injury at 4:33 p.m. intervention was to redirect to sit down in dining room.
2/25/18, in dining room, with no injury, at 11:50 a.m. intervention was to have therapy screen.
3/20/18, in hallway with 5.0 x 5.0 centimeter (cm)

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bump on right side of head at 4:40 p.m. intervention placed on 1:1 for short period, 30 minutes due to aggression.
4/6/18, in dining room/lounge with no injury at 2:10 p.m. the intervention was medical workup.
4/22/18, in dining room with no injury at 2:20 p.m. the intervention was to attempt to redirect from other residents.
5/8/18 in the lounge with no injury at 11:00 a.m. the intervention was redirect resident from other resident's space.
5/24/18, in another resident's room/bathroom with no injury at 10:00. The intervention was to do 3 day bowel and bladder study.
6/7/18 in the dining room with no injury at 5:15 p.m. the intervention was to offer rest periods with fluids and snacks.
7/26/18, by the nurse's station at 3:40 p.m. sent to the emergency room, resulted in a hip fracture. Had surgery on 7/27/18, returned to facility on 7/31/18.
8/2/18, in bedroom with no injury at 3:30 p.m. intervention was offer to lay down after lunch.
8/7/18, in dining room with no injury at 6:15 p.m. the intervention was chair pad alarm on wheelchair.
8/9/18, in dining room with no injury at 8:30 p.m. the intervention was continue with therapy to help get stronger to use walker.
R147 had between 11 and 15 falls (conflicting information in the chart and on the fall log) prior to the fall with hip fracture on 7/26/18; and 1 to 3 falls after returning to the facility. The facility lacked patient centered interventions, or different interventions for each fall.
R26's Admission Record printed on 8/23/18, indicated R26 had diagnoses that included repeated falls and dementia.
R26's annual MDS dated 6/6/18, indicated R26

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had cognitive loss and dementia, impaired communication, and had a decline in continence R26's care plan revised 12/31/16, indicated the R26 wandered, rummaged, and shopped through others belongings, and believed they were hers. The care plan indicated R26 would yell and become angry with redirection, was at risk for falls related to history of falls, impaired mobility, medication, Alzheimer's and need for assist with cares. On 6/6/18, a hand written note indicated scoop mattress, gripper socks at bedtime, bed at seated heights, non-skid footwear. Frequent checks while in bed, attempt to redirect resident then having increased behaviors. The care plan indicated R26 ambulated with walker, but did not indicate that R26 would walk away from walker, or leave walker behind objects.

On 8/20/18, at 7:55 p.m. R26 was observed walking away from the dining room without her walker, RN-H noticed after R26 had walked the length of the dining room to the nurse's station, at least 15 feet.

On 8/21/18, at 9:49 a.m. R26 was observed walking through the dining room without her walker. A housekeeper brought it to her. NA-D and NA-H were in dining room, and did not notice. A nurse passing medications did not notice.

On 8/21/18, at 10:06 a.m. R26 was observed 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?"

On 8/21/18, at 10:16 a.m. R26 was observed walking without her 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.

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R26's medical chart was reviewed and indicated the following falls:
On 10/14/17, at 12:17 a.m.. Found sitting on side mat on floor next to the bed in another resident's room. Was alert, smiling, stated, "I got down here, now I can't get up." Denied injury or pain. Able to move all extremities independently. Assisted to stand and walked with staff to her room without problem. Neuro check intact.
On 11/21/17, at 5:32 p.m. One week follow-up note (R26's medical record lacked documentation of a fall one week prior). Resident appears to be at baseline, no residual effects noted post fall, no injuries observed, denies pain at time of assessment.
On 12/13/17, at 5:02 p.m. Resident had witnessed fall. Per witness statements resident was standing at nurses station and backed up. Another resident reached out for her and grabbed her hand, and pulled her back causing resident to lower herself to the ground. Resident laughed and stated, "I'm okay, 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 heard walker fall on the ground, and found resident lying on right side on the ground. NA notified writer, and writer assessed resident. ROM to all extremities per baseline, denies pain. Writer assisted resident to lie down in bed as it was reported she did not sleep through the night last night.
On 1/11/18, at 8:55 a.m. Resident had a witnessed fall at approximately 8:00 a.m. Writer assessed resident and noted a golf ball sized lump to left side of head. Resident denied pain however, when asked if she was in pain held the left side of her head. Some weakness noted to bilateral hands/legs and weak gait, send resident

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to Emergency Room for evaluation due to lump on head. Resident left via ambulance at approximately 8:45 a.m. At 11:09 received update from Emergency Room, CT [Cat Scan] of head, shoulder and spine negative.
On 5/7/18, at 1:21 p.m. R26 had an witnessed fall in main dining room next to counter where packages of sugar, creamers, are located. She hit her head on wall and railing. She has one inch swelling on back of her head. Neuro/vitals started, able to move all extremities, dry brief; took to bed and has stayed in her bedroom. Applied ice pack to back of head. Placed on 15 minute checks
On 5/29/18, at 10:45 p.m. Resident found sitting on floor two separate times. #1. Sitting on floor on buttocks, holding head. #2. Found in another resident's room sitting on floor with walker in front of resident. No injury. Staff monitoring with 15 minute checks initiated at 10:15 p.m.
On 7/13/18 at 7:10 p.m. Unwitnessed fall of resident in hall. Resident was lying flat down on floor with snacks and other things in her hands. Bridge of nose had 3 cm lesion that was bleeding; cleaned and applied bandage. Resident nose was bent. Used Hoyer to wheelchair, sent to Emergency Room for evaluation at 8:30 p.m. Resident returned around 12:30 a.m. by ambulance with papers indicating CT scan was normal, and expect resident to be stiff and sore for the next few days. Resident is sleeping in bed at this time.
According to the facility fall log R26 had 10 falls:
11/30/17, fell in another residents room, with unnamed injury, at 11:20 a.m. Intervention was sent to Emergency Room for evaluation.
12/13/17, fell by nurses station with no injury at 3:20 p.m. Intervention indicated, "None see nursing note"

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35 12/13/17, in another resident's room, received skin tear, at 8:20 p.m. The interventions was, MD to evaluate medications at the next scheduled visit [there was no indication when MD-A would be there]. 1/11/018, in resident's room with unnamed injury, at 8:00 a.m. The interventions listed were sent to Emergency Room for evaluation, orthostatic blood pressure x 3 days, Debrox drops [for ears]. 4/3/18, at nurse's desk with no injury at 11:15 p.m. The intervention was to remind staff to put on gripper socks and use walker. 5/6/18, in main dining room with no injury at 11:45 p.m. The intervention was a 7 day sleep study. 5/29/18, in hallway at 8:30 p.m. with unnamed injury and 10:15 p.m. with no injury. The intervention was notified MD in regards to fall, no medications. 7/13/18, at nurse's station with no injury at 11:15 a.m. No interventions were listed. 7/13/18, in hallway at 7:10 p.m. No interventions were listed. R26 was sent to the Emergency Room and returned at 112:30 a.m. on 7/14/18, with no injuries per CT scan. 8/10/18, at nurse's station, no injuries, at 6:10 p.m. The intervention was 3 day orthostatic blood pressures and therapy. R26's fall logs did not match chart documentation, and identified interventions did not coincide with the cause of the falls. The facility lacked a coordinated and resident centered approach to falls.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 693		10/2/18

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F 693	Continued From page 36 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This 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. Findings include: R148's admission Minimum Data Set (MDS) dated 8/15/18, indicated diagnoses that included dysphagia (difficulty swallowing, traumatic brain injury (TBI) and muscle weakness. In addition, the MDS identified R148 received tube feeding. R148's Physician Order dated 8/8/18, indicated R148 had an order for Jevity 1.0 (nutrition for tube feeding), 65 milliliter (ml) per/hour for 21	F 693	F693 □ Tube Feeding: " R148 is receiving tube feeding as ordered, and medications are given according to standards of practice. " Other residents with tube feeding are receiving the feeding as ordered, and medications are given according to standards of practice. " Licensed nurses have been re-educated regarding facility expectations for tube feeding services and medication administration. " Licensed nurses have been re-educated regarding tube feeding policy and tube feeding medication administration policy. " Observational audits of medication administration through a g-tube are conducted with nursing staff to monitor for	

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F 693	Continued From page 37 hours continuously from 8:00 a.m. to 5:00 a.m. In addition, a physician order dated 8/9/18, indicated R148 was to receive 150 ml water flushes via gastrostomy (g) tube four times daily for a total of 600 ml. R148's care plan dated 8/16/18, indicated R148 did not receive anything by mouth, and she received tube feeding. The care plan indicated 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 preparing R148's medications. RN-D crushed seven different medications in separate plastic bags and mixed two packets of powdered Potassium Chloride 20 milliequivalent (mEq) in five ounces of water. RN-D stated she was going to give all the medications via g-tube. At 8:11 a.m. RN-D arrived at R148's room, went to the bathroom and obtained 200 ml of water in a graduate cylinder. RN-D approached R148, indicated she was going to administer medications and start her enteral feeding via g-tube. RN-D pulled the bedside table and set down the small cup with Potassium Chloride mixed in water, and the rest of R148's morning medications crushed in little plastic bags. After applying gloves, RN-D was picked up the g-tube, removed the tab closure, and inserted a syringe with air into the feeding port as she listened with a stethoscope to check for tube placement. RN-D clamped the g-tube, took the syringe off the port, then separated the barrel and plunger. RN-D inserted the barrel into the g-tube port and administered 15 ml of water, clamped the g-tube,	F 693	medications given according to standards of practice. These audits will be completed by ADON or Nurse Manager two audits weekly x4, then two audits every other week x2, then as directed by the QAPI.	

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F 693	Continued From page 38	F 693		

poured the Potassium Chloride liquid into the barrel and flushed with 10 ml of water. RN-D clamped the g-tube and poured another 10 ml of water into the barrel. RN-D emptied the crushed medication powder into the water in the barrel, and released it to adminsitered the medications. RN-D followed this with a 10 ml flush of water. RN-D repeated this process of emptying the crushed powdered medications five times without mixing the medications with water before pouring them into the barrel. Once finished, RN-D went into the bathroom and obtained another 200 ml of water. RN-D returned to R148's bed side, and flushed the tube. RN-D continued to administer the crushed powdered medications on two separate occasions followed by water flushes. RN-D stated she had used a total of 350 ml of water to complete the water flushes. RN-D removed her gloves, dumped the remaining 50 ml of water, cleansed her hands, and left the room without starting R148's tube feeding.

At 8:25 a.m. RN-D reviewed R148's physician orders and verified R148 was to receive 150 ml of water flushes four times a day. RN-D stated she had given R148 more water because she had a problem with medications not draining, and she was going to hold off the tube feeding "To let the medications settle." RN-D stated she had not mixed the medications prior to administering them, because she had asked RN-E, who told her she would pour the powder into the syringe barrel with water 5 ml to 10 ml of water, and then follow with a water flush of the same amount. RN-D stated she did not know the policy on tube feeding, and that was why she had asked RN-E. RN-D further stated she was going to hold off on starting the tube feeding.

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F 693	Continued From page 39 On 8/22/18, at 8:50 a.m. RN-E stated medications should have been dissolved in water using the little medication cups before g-tube administration. RN-E stated R148 should have not gotten the extra water (200 ml of water flush). RN-E stated she was not aware the tube feeding was not running as ordered, and RN-D should have gotten an order to hold the tube feeding from the nurse practitioner (NP). RN-E verified R148's tube feeding was supposed to be running from 8:00 a.m. to 5:00 a.m. (21 hours continuously) On 8/22/18, from 8:52 a.m. to 9:01 a.m. the tube feeding was observed not running. At 9:02 a.m. RN-E approached and stated she had gotten an order to hold the tube feeding for three hours due to the extra water given and would re-start the tube feeding 11:00 a.m. On 8/22/18, at 1:40 p.m. RN-F verified the RN-D had not demonstrated competency skills related to medication administration through a g-tube. RN-F stated all the licensed nursing staff had a clinical check list. On 8/22/18, at 1:49 p.m. the director of nursing (DON) stated she would have expected the nurse to dissolve the medications in water before administering them according to the facility policy. The DON stated RN-D should have followed the physician orders for the water flushes, and should have started the tube feeding timely as ordered, and if not, to get an order to hold it.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		10/2/18

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F 695	Continued From page 40 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was replaced in a timely manner, and failed to clean a nebulizer mask for 1 of 1 resdients (R35) reviewed for respiratory care. Findings include: R35's quarterly Minimum Data Set (MDS) dated 6/14/18, indicated R35 had intact cognition and required extensive assitance with all activities of daily living. R35's care plan dated 5/18, identified diagnosis of chronic obstructive pulmonary disease and oxygen use daily. R35's medication administration record (MAR) and treatment administration record (TAR) directed night shift nurse to clean Bi-PAP (bilevel positive airway pressure) machine every Wednesday, and change nebulizer tubing and equipment weekly on Thursday. On 8/20/18, at 6:59 p.m. R35 stated staff were supposed to change his oxygen tubing every week and stated, "I don't think they did." R35 further stated getting his BI-PAP machine clean	F 695	F695 □ Respiratory Care: " Oxygen tubing for R35 has been replaced, and the nebulizer mask cleaned. This has been added to the treatment administration record for weekly replacement. It is being completed and documented weekly. " Other residents using oxygen and/or nebulizer treatments have their oxygen tubing replaced timely, and/or nebulizer masks cleaned. " Residents receiving oxygen and/or nebulizer treatment have been reviewed to ensure that the tubing replacement/mask cleaning is on the treatment administration record for weekly replacement. " Audits to monitor completion and documentation of the tubing replacement/mask cleaning will be conducted by the Nurse Managers two audits weekly x4, then two audits every other week x2, then as directed by QAPI.	

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F 695	Continued From page 41 was his biggest complaint. On 8/23/18, at 9:08 a.m. R35's oxygen tank was observed in his room. Attached to the oxygen tubing was a piece of tape dated 7/21/18. R35's nebulizer machine was sitting on top of a side table. The mask was attached to the machine, and had visible condensation. On 8/23/18, at 9:27 a.m. licensed practical nurse (LPN)-D sated the night shift was responsible for changing the oxygen tubing. LPN-D stated the nebulizer machine was supposed to be cleaned after each use. She stated R35's nebulizer treatment was scheduled to be given as needed, and she had not given one on her shift. LPN-D stated whoever gave the last nebulizer treatment should have cleaned the machine. On 8/23/18, at 9:30 a.m. LPN-B stated oxygen tubing should be replaced weekly on the overnight shift. LPN-B stated the nebulizer machine mask should be cleaned every day after use. He stated the nurses know they are supposed to change the tubing weekly. A facility policy titled Nebulizer Therapy dated April 2009, indicated staff should disconnect the tubing after use, shake out the excess liquid, and air dry the nebulizer cup. A facility policy titled Oxygen Administration dated March 1, 2014, directed staff to replace oxygen tubing weekly and as needed.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff.	F 725		10/2/18

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F 725	Continued From page 42 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate staff to provide care for residents on the Cedar Unit. This had the potential to affect all 40 residents residing on the unit. Findings include: On 8/20/18, at 4:54 p.m. the food arrived in the Cedar dining room for the evening meal. Staff did not finish serving the the meal until 6:15 p.m. The	F 725	F725 □ Sufficient Nursing Staff: " Meals are being served according to the posted schedule. " The DON and Nurse Managers have reviewed the nursing assistant routines. The routines have been adjusted for efficiency. " Resident 35 is encouraged to get up and come out to the dining room for meals.	

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F 725	Continued From page 43 evening meal was scheduled for 5:25 p.m. R35's 14 day Minimum Data Set (MDS) dated 7/10/18, indicated he was moderately cognitively impaired, and required assistance for transfers and toileting. During interview on 8/20/18, at 6:28 p.m. R35 stated he had a challenge getting up for breakfast in the morning. He stated he did not like eating in bed, and sometimes the facility was understaffed and he missed breakfast. He stated this had happened recently. A review of a device activity report dated 8/19/18, indicated R35's call light was on 8/18/18, at 7:14 a.m. and was not answered until 8:32 a.m. a total of 1 hour and 20 minutes. On 8/19/18, R35's call light was turned on at 7:05 a.m. and not answered until 7:39 a.m. a total of 34 minutes and 11 seconds. R69's quarterly MDS dated 6/14/18, indicated he had intact cognition, and required extensive assitance with all activities of daily living. During an interview with R69 on 8/20/18, at 1:59 p.m. family member (FM)-B stated she was at the facility a lot. FM-B stated R69's call light took a long time to be answered, and stated sometimes it went for up to 25 minutes without being answered. R69 stated he almost always had to go to the bathroom in his pants. R95's annual MDS dated 7/25/18, indicated he was severely cognitively impaired, and required extensive assistance with all activities of daily living. The MDS further indicated it was very important to R95 that he was able to participate in	F 725	" Residents are encouraged to come out to the dining room for meals. " Call lights are answered timely for R35, R69, R11, R48, R150, R122 and all residents. " Resident 95 no longer resides at Chris Jensen. " Nursing staff have been re-educated regarding facility expectation for meeting resident needs. If staff are unable to meet resident needs, staff have been educated/instructed to notify the unit charge nurse or nurse manager. " Audits to monitor compliance will be conducted two audits weekly x4, then two audits every other week x2, then as directed by QAPI.	

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F 725	Continued From page 44	F 725		

his favorite activities. R95's care plan dated 7/26/18, identified dementia with behavioral disturbance, and directed staff to anticipate and met his needs, offer choices regarding daily care and reorient as needed. The care plan further identified behaviors that included: easily frustrated, especially when R95 could not hear, or staff did not respond quickly and directed staff to check for hunger, thirst, pain or activity needs.

During an observation on 8/22/18, at 7:05 a.m. R95 was in his wheelchair self-propelling around the dining room. At 7:12 a.m. R95 was in front of the nurses station desk requesting to call his brother. Licensed practical nurse (LPN)- B told R95 to give him a little bit, and he would find the number for him. At 7:21 a.m. R95 was propelling himself down the hallway. A staff member pushed him back into the dining room where a television was on, turned to a talk show. At 7:39 a.m. R95 was again propelling himself in the dining room. At 7:46 a.m. R95 attempted to exit the unit via an open elevator door. Registered nurse (RN)-B intervened and told him he needed his hearing aides. R95 asked RN-B who she was and called her a name. At 7:50 a.m. R95 was again escorted back a table in the dining room by a staff member, but was not offered anything to eat or drink. There was nothing on the table except a linen napkin and a box of tissues. R95 began emptying the box of tissues onto the table At 8:05 a.m. R95 propelled himself away from the dining room table. At this time, a radio was playing tuned to a country station, three other men were sitting at the table but no one was talking. Three other residents were sitting in the dining room with their eyes closed, a fourth resident was sitting in a wheel chair with her hands covering her face and another resident sat alone at a table with her

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F 725	Continued From page 45	F 725		

arms crossed in front of her. There was no attempt by staff to engage R95 or the other resdients during the observation. At 8:18 a.m. R95 made another attempt to exit the unit through the elevator door. Staff again intervened and did not allow him to leave. R95 pushed the elevator button again and a staff member brought him back to his table in the dining room and walked away. At 8:23 a.m. R95 propelled away from the table and headed back to the elevator. At 8:25 a.m. the elevator door opened and R95 attempted to exit but his wheel chair was stuck on the wall preventing him from moving. At 8:27 a.m. the elevator door opened again and R95 again attempted to get in. A staff member brought him back to the table in the dining room. At 8:33 a.m. R95 threw a napkin on the floor. A resident seated at the table picked up the napkin and gave it to R95. R95 threw the napkin under the table a second time and attempted to stand up out of the wheel chair to pick it up. At 8:36 a.m. R95 attempted to get out of his wheel chair to pick up the napkin. While trying to kneel on the floor, R95 fell onto his right side on the floor.

On 8/22/18, at 9:13 a.m. staff began serving the breakfast meal on the unit. The meal was scheduled to begin at 8:00 a.m.

R11's annual MDS dated 5/23/18, indicated he was cognitively intact, and required extensive assistance for bed mobility, toileting, and transfers. The MDS further indicated R11 was always continent of bowel and bladder.
.
On 8/21/18, at 2:37 p.m. R11's family member (FM)-C stated she visited the facility daily. FM-C stated she had gone to LPN-B several times about the call light system. She stated R11 knew

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

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how long his call light stayed on, and stated she felt like it affected his quality of life when he had to wait to use the bathroom. FM-C stated staff assisted R11 to the bathroom, and said they would watch for the call light, but would not answer it. FM-C stated if R11 had to wait too long for his call light to be answered he would bang on the bathroom wall. FM-C stated it was disheartening when she got to the facility and another residents told her R11 was banging on the wall. FM-C further stated she had asked LPN-B not to assign the new staff to R11, because she ended up having to train them in and stated, "That's not my job."

R48's annual MDS dated 6/20/18, indicated he was moderately cognitively impaired, required extensive assitance from two staff for bed mobility, transfers, and toileting. The MDS also indicated R48 was always incontinent of bowel and bladder.

On 8/22/18, at 1:46 p.m. R48's family member (FM-D) stated she did not feel her R48 was safe when she was not at the facility. FM-D stated R48's face was never washed, and his teeth were never brushed. FM-D stated one day she arrived at the facility to find R48 hanging out of bed and lying in a urine soaked incontinence brief. FM-D stated the weekends were "horrible," and stated another day she had come to the facility, and R48's bed had urine soaked sheets under the comforter. FM-D stated she had concerns about a specific staff member, and had spoken to LPN-B several times about her concerns. FM-D stated she felt like there was a lack of staff, and a lack of competent staff on the unit, and stated no one was overseeing the staff on the unit. FM-D further stated there were not enough staff to get

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everyone up to a meal in time.

On 8/22/18, at 7:41 a.m. LPN-C stated although there were five NA's working on the unit that morning, there were usually only four. LPN-C also stated she was the third nurse on the unit that morning and stated that also wasn't typical. LPN-C stated the facility did not schedule staff by acuity and stated, "It's hard, I almost never get a break."

On 8/22/18, at 1:27 p.m. RN-B stated there were usually four NA's scheduled on the unit and two nurses. RN-B stated it was typical to serve breakfast at 9:00 a.m. RN-B stated although there were several additional staff in the dining room that day, they were not usually there.

On 8/22/18, at 1:34 p.m. LPN-B stated the facility staffed based on census. He stated when the unit had 40 residents the facility would schedule an additional aide for four hours. LPN-B stated if the census dropped to 39 there were four NA's scheduled. LPN-B stated there was no change in the staffing levels if acuity increased. LPN-B stated he had received complaints from families related to long call light wait times, had concerns from a few residents, and had heard in general, staff felt like they needed more help. He stated the longer call light times were generally around meal times.

A review of facility Grievance Forms identified the following:

5/8/18, R11 reported he had a "rough few days." He reported call light wait times of 30 minutes and reported being left on the toilet for 30 minutes. FM-C stated she felt like R11 only

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received care when she was in the facility to look after his needs. The report indicated LPN-B spoke with staff and explained the call lights were important, and they needed to work as a team to prevent long call light wait times.

6/13/18, R150 reported call lights took too long to be answered. The report indicated a call light audit was performed, and R150 had a legitimate complaint. Call lights were on longer than the facility would like. The report indicated LPN-B spoke with staff on importance of call lights, and indicated facility would work with staff to come up with better options to meet resident needs.

8/2/18, R122 reported his call light was not being answered in the afternoon. R122 reported he had to wait 45 minutes, and stated sometimes staff did not come at all. A call light audit was performed and identified a wait time of over 27 minutes on 7/31/18.

8/16/18, R77 reported the NA's always tell her they are too busy to help her. A section of the form labeled Grievance Resolution indicated R77 stated she did not remember saying this, and stated it could have been from another unit as she had recently moved. The grievance form indicated grievance not confirmed and no action taken.

During interview on 8/23/18, at 10:29 a.m. R77 stated, "I do remember saying that, it tends to be on the true side."

On 8/23/18, at 1:20 p.m. LPN-B stated he recalled a concern about a staff member from FM-C. LPN-B stated the concern was that the staff member didn't know R11 well, and felt there

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F 725	Continued From page 49 was a lack of consistency in staffing. LPN-B stated when a family member came to him with a concern he would try to address it and correct it right away if he could. He stated he would talk to the employee, but would not necessarily document the conversation. LPN-B did not recall a concern about the NA by FM-D. On 8/23/18, at 3:01 p.m. the human resources director (HRD) and the director of nursing (DON) were interviewed. The HRD stated staff met every morning to discuss census, potential admissions, and acuity changes. The HRD stated if staff expressed concerns related to staffing levels, she encouraged them to go to the nurse manager or team lead. The DON stated the nurse managers were responsible for following up on staffing concerns by residents, families and staff. The DON stated concerns were documented and audited to ensure follow up. In regard to the meals running late on the units, the DON stated meals were running late on units because NA's are still getting people up. She stated she was aware they were a little late, but did not realize it was typical to be routinely late.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 726		10/2/18

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F 726	Continued From page 50 accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This 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. Findings include: R148's admission Minimum Data Set (MDS) dated 8/15/18, indicated diagnoses that included dysphagia (difficulty swallowing, traumatic brain injury (TBI) and muscle weakness. In addition, the MDS identified R148 received tube feeding. R148's Physician Order dated 8/8/18, indicated R148 had an order for Jevity 1.0 (nutrition for	F 726	F726 □ Competent Nursing Staff: " R148 is receiving tube feeding and medication administration according to standards of practice. " Other residents with tube feedings are receiving medication administration according to standards of practice. " Licensed nurses have been re-educated regarding facility expectations for medication administration through a tube feeding. " Skills check off for administration of medication through a tube feeding has been added to orientation for new hire licensed nurses. " Observational audits by ADON or designee to review for competence in the	

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F 726	Continued From page 51 tube feeding), 65 milliliter (ml) per/hour for 21 hours continuously from 8:00 a.m. to 5:00 a.m. In addition, a physician order dated 8/9/18, indicated R148 was to receive 150 ml water flushes via gastrostomy (g) tube four times daily for a total of 600 ml. R148's care plan dated 8/16/18, indicated R148 did not receive anything by mouth, and she received tube feeding. The care plan indicated 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 preparing R148's medications. RN-D crushed seven different medications in separate plastic bags and mixed two packets of powdered Potassium Chloride 20 milliequivalent (mEq) in five ounces of water. RN-D stated she was going to give all the medications via g-tube. At 8:11 a.m. RN-D arrived at R148's room, went to the bathroom and obtained 200 ml of water in a graduate cylinder. RN-D approached R148, indicated she was going to administer medications and start her enteral feeding via g-tube. RN-D pulled the bedside table and set down the small cup with Potassium Chloride mixed in water, and the rest of R148's morning medications crushed in little plastic bags. After applying gloves, RN-D was picked up the g-tube, removed the tab closure, and inserted a syringe with air into the feeding port as she listened with a stethoscope to check for tube placement. RN-D clamped the g-tube, took the syringe off the port, then separated the barrel and plunger. RN-D inserted the barrel into the g-tube port and	F 726	skill of medication administration through a tube feeding have been conducted with licensed nurses. " Observational audits by ADON or designee will continue two audits weekly x4 weeks, then two audits a week every other week x2, then as directed by QAPI.	

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F 726	Continued From page 52	F 726		

administered 15 ml of water, clamped the g-tube, poured the Potassium Chloride liquid into the barrel and flushed with 10 ml of water. RN-D clamped the g-tube and poured another 10 ml of water into the barrel. RN-D emptied the crushed medication powder into the water in the barrel, and released it to adminsitered the medications. RN-D followed this with a 10 ml flush of water. RN-D repeated this process of emptying the crushed powdered medications five times without mixing the medications with water before pouring them into the barrel. Once finished, RN-D went into the bathroom and obtained another 200 ml of water. RN-D returned to R148's bed side, and flushed the tube. RN-D continued to administer the crushed powdered medications on two separate occasions followed by water flushes. RN-D stated she had used a total of 350 ml of water to complete the water flushes. RN-D removed her gloves, dumped the remaining 50 ml of water, cleansed her hands, and left the room without starting R148's tube feeding.

At 8:25 a.m. RN-D reviewed R148's physician orders and verified R148 was to receive 150 ml of water flushes four times a day. RN-D stated she had given R148 more water because she had a problem with medications not draining, and she was going to hold off the tube feeding "To let the medications settle." RN-D stated she had not mixed the medications prior to administering them, because she had asked RN-E, who told her she would pour the powder into the syringe barrel with water 5 ml to 10 ml of water, and then follow with a water flush of the same amount. RN-D stated she did not know the policy on tube feeding, and that was why she had asked RN-E. RN-D further stated she was going to hold off on starting the tube feeding.

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F 726	Continued From page 53 On 8/22/18, at 1:40 p.m. RN-F verified RN-D had not demonstrated competency skills related to medication administration through a g-tube. RN-F stated all the licensed nursing staff had a clinical check list. RN-F stated both LPN's and RN's had the same clinical requirements in the checklist.	F 726		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dementia services were provided for 1 of 3 residents (R95) reviewed for dementia care . Findings include: R95's annual Minimum Data Set (MDS) dated 7/25/18, indicated he was severely cognitively impaired, and required extensive assistance with all activities of daily living. The MDS further indicated it was very important to R95 that he was able to participate in his favorite activities. R95's care plan dated 7/26/18, identified dementia with behavioral disturbance and directed staff to anticipate and met his needs, offer choices regarding daily care and reorient as needed. The care plan further identified behaviors that included: easily frustrated, especially when R95 could not hear or staff did not respond quickly and directed staff to check for hunger, thirst, pain	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 the Behavioral Health Policy in reference to Dementia Services facility expectations.	10/2/18

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F 744	Continued From page 54 or activity needs. On 8/22/18, at 7:05 a.m. R95 was observed in his wheelchair self-propelling around the dining room. At 7:12 a.m. R95 was in front of the nurses station desk requesting to call his brother. Licensed practical nurse (LPN)-B told R95 to give him a little bit, and he would find the number for him. At 7:21 a.m. R95 was propelling himself down the hallway. A staff member pushed him back into the dining room where a television was on, turned to a talk show. At 7:39 a.m. R95 was again propelling himself in the dining room. At 7:46 a.m. R95 attempted to exit the unit via an open elevator door. registered nurse (RN)-B intervened and told him he needed his hearing aides. R95 asked RN-B who she was and called her a name. R95 was again escorted back to a table in the dining room by a staff member, but was not offered anything to eat or drink. There was nothing on the table except a linen napkin and a box of tissues. R95 began emptying the box of tissues onto the table At 8:05 a.m. R95 propelled himself away from the dining room table. At this time, a radio was playing, and three other men were sitting at the table but no one was talking. Three other residents were sitting in the dining room with their eyes closed, a fourth resident was sitting in a wheel chair with her hands covering her face, and another resident sat alone at a table with her arms crossed in front of her. There was no attempt by staff to engage R95 or the other resdients during the observation. At 8:18 a.m. R95 made another attempt to exit the	F 744	" Activity calendar for Cedar and Willows has been reviewed and revised if indicated with an emphasis on assisting with engagement and dementia services. " Observational audits to monitor for interaction and engagement on the part of staff with residents requiring dementia services will be conducted by the Activity Director or designee in collaboration with the nurse manager. These audits will occur two audits weekly x4 weeks, then two audits every other week x2, then as directed by QAPI.	

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F 744	Continued From page 55	F 744		

unit through the elevator door. Staff again intervened and did not allow him to leave. R95 pushed the elevator button again and a staff member brought him back to his table in the dining room and walked away. R95 propelled away from the table and headed back to the elevator. The elevator door opened, and R95 attempted to exit but his wheel chair was stuck on the wall preventing him from moving. The elevator door opened again, and R95 again attempted to get in. A staff member brought him back to the table in the dining room. R95 threw a napkin on the floor. A resident seated at the table picked up the napkin and gave it to R95. R95 threw the napkin under the table a second time and attempted to stand up out of the wheel chair to pick it up. At 8:36 a.m. R95 attempted to get out of his wheel chair to pick up the napkin. While trying to kneel on the floor, R95 fell onto his right side on the floor. LPN-C responded to the fall and stated to R95, "You did that on purpose didn't you?" LPN-C then stated to another staff member, "He so did that on purpose." LPN-C turned to R95 and again asked him why he put himself on the floor. At 8:38 a.m. R95 was still lying on the floor. LPN-C stated to R95, "You threw yourself on the floor, why did you do that?" At this time, R95 remained on the floor with five staff members standing over him. R95 displayed signs of agitation. He attempted to hit staff and squeezed LPN-C's hand, pointed at her with the other hand and stated, "It was you." The certified nurse practitioner walked over to where R95 was lying and asked what happened. LPN-C stated R95 put himself on the floor, and stated he had been wild all night, throwing things and trying to punch staff. During the observation there were no attempts by staff to offer R95 fluids, food, toileting or any staff or activity engagement.

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On 8/23/18, at 9:49 a.m. nursing assistant (NA)-B stated R95 had a lot of behaviors. She stated his behaviors included putting himself on the floor, and stated staff keep him by the nurses station. She stated recently R95 got mad that staff were keeping him there, and he threw a Kleenex box at the nurse. NA-B stated she did not know if R95 was able to comprehend what was happening, and stated he understands simple cues. She stated his behavior interventions included things such as getting him something to eat or trying to make him more comfortable.

On 8/23/18, at 10:15 a.m. LPN-D stated R95 thought he was in jail in the facility. She stated he doesn't understand why he's here, and thinks he can leave. LPN-D stated R95 had hallucinations and delusions, and complained that no one was paying attention to him. LPN-D stated when R95 displayed behaviors staff would call his daughter.

On 8/23/18, at 10:33 a.m. LPN-B stated R95 had a diagnosis of dementia with behaviors, and stated much of it was attention seeking. LPN-B stated there were many interventions in place. LPN-B stated in the past staff tried to get him on a one to one with activities, but stated R95 did not participate. LPN-B stated R95 was fixated on what he wants, and if he didn't get it he became aggressive.

At 8/23/18, at 11:01 a.m. family member (FM)-A stated R95 has told him he will lay in bed for hours and no one will show up. FM-A stated R95 told him falling was how he got them to pay attention.

At 11:15 a.m. LPN-B stated R95's behavior and

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F 744	Continued From page 57 interest information should be on the group sheet. He stated the behavioral care plan was developed by the interdisciplinary team. LPN-B stated staff know to ask questions about things that have helped with R95's behaviors in the past. LPN-B stated R95 was constantly asking to use the phone to call his daughter, but the daughter has been declining that as an intervention. LPN-B stated if R95 was being aggressive or grabbing stuff, staff would persuade him to go to the solarium and give him time to express what he needed. He stated if staff needed interventions they were supposed to go to the nurse or trained medication aide, and they would come up with an intervention. A facility policy related to dementia care was requested but not received.	F 744		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		10/2/18

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 58 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure stock medications were not discarded when expired on 2 of 5 medication carts reviewed for medication storage. Findings include: On 8/23/18, at 1:00 p.m. the Cedar 1 medication cart was observed with licensed practical nurse (LPN)-D. The cart contained the following expired stock medications: one bottle of Aspirin 325 mg (milligrams) expired on 9/17. LPN-D verified the expiration dates, and stated she didn't think any residents received the medication. On 8/23/18, at 1:10 p.m. the Cedar 2 medication cart was observed with registered nurse(RN)-B. The cart contained the following expired stock medication: 2 bottles of aspirin 325 mg expired on 1/18, and 1 bottle of loperamide 2 mg expired 1/18. RN-B verified the expiration dates, and stated she didn't think any residents were receiving those medications. Review of facility policy dated April 1, 2008, and revised March 1, 2014, directed all medications which are no longer being administered to the residents will be removed and appropriately	F 761	F761 □ Drug Label/Storage: " The bottles of over the counter stock medications that were in the med carts and past their expiration date were removed and appropriately discarded. " The supply of over the counter stock medications in the medication carts, medication rooms, and central supply have been checked to ensure there are no medications past their expiration date. " All medications no longer being administered to residents are removed and appropriately discarded. " Licensed nurses and TMAs have been re-educated about facility expectations for checking all medications to include over the counter stock medications for expiration date prior to medication administration. " Over the counter stock medications have been specifically added to the form used for routine audits of expiration dates on medications stored in the med carts. " Audits to monitor compliance will occur	

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F 761	Continued From page 59 discarded. PROCEDURE 1. All discontinued medications are kept locked until destroyed. 2. All medications which have passed the expiration date on the label are properly disposed and re-ordered, if necessary. 3. Rarely used PRN (pro re nata), i.e., as needed, medications are not kept longer than one year from the date of issue on the label, unless it has an earlier expiration date. The PRN medication must be available until the order is discontinued. 4. Medications are disposed of in accordance with state and federal regulations. 5. Medications are not given to the resident's family unless there is a physician's order to do so. See also Pharmacy Manual for additional information. The director of nursing (DON) indicated via email on 8/24/18, the policy would include stock medications.	F 761	two audits weekly x 4 weeks, then two audits every other week X2 then as directed by QAPI. The nurse managers or designee are responsible for this audit.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 804	F804 □ Food temps:	10/2/18

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F 804	Continued From page 60 review, the facility failed to ensure food was served at a palatable and appetizing temperature for 1 of 6 residents (R4) receiving pureed food. Findings include: R4's Admission Record printed 8/23/18, indicated R4 had diagnoses that included unspecified dementia and Alzheimer's disease. R4's quarterly Minimum Data Set (MDS) dated 5/3/18, indicated R4 had moderately impaired mental status, and required set up assistance, and encouragement or cueing with eating. R4's diet order dated 4/08/18, directed a low salt diet, low fat/cholesterol 3 gram sodium diet. R4's care plan printed 8/16/18, indicated R4 was edentulous (lacking teeth) and received a pureed, low sodium, low fat, low cholesterol diet with honey (textured) liquids. On 8/20/18, at 4:54 p.m. the supper food temperatures taken by dietary aide (DA)-A included french fries at 135 degrees Fahrenheit (F) and mashed potatoes at 132 degrees F prior to beginning food service. No action was taken to improve the temperature of these menu items. DA-A began serving meals at 5:25 p.m. On 8/22/18, at 1:20 p.m. as the last food trays were served to residents, pureed meatloaf registered a temperature of 100 degrees F, and pureed spinach was 110 degrees F with DA-B. Food temperatures were not observed to have been taken during the meal service and action to reheat foods was not observed. On 8/23/18, at 11:19 a.m. R4 stated the food he	F 804	" Food temp logs for 8/20/18 supper food temps prior to beginning of meal service include: French fries at 170 degrees, and mashed potatoes at 152 degrees. " Pureed food temps on 8/22/18 at 1:20 pm were taken after all the pureed foods had been served and the food tray was empty except for small amounts scraped off the sides of the tray per surveyor request for pureed temp. " Food is served at a palatable and appetizing temperature for R4 and other residents receiving pureed food. " Procedure for ensuring that hot food served maintains temperature of 140 degrees or above was reviewed and updated. " Mid-meal temperature reading was added to the process to monitor maintenance of food temperatures. " Dietary staff have been re-educated regarding the procedure for maintaining the food temperature during steam table service, and the addition of mid-meal temperature readings. " Dietary Director or designee will audit initial and mid-meal temperatures 3 x week for 4 weeks; then 2 times a week for 2 weeks; then 1 time a week for 2 weeks, then as directed by QAPI.	

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F 804	Continued From page 61 received was sometimes not hot. On 8/23/18, at 1:33 p.m. the dietary manager (DM) stated when food temperatures of hot foods in the dining rooms are low, food service staff are supposed to call the kitchen and kitchen staff would bring the food back to the kitchen and re-heat it.	F 804		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure substantial evening snacks were offered for 3 of 3 residents (R128, R4, R118) who received meals in the Cedar unit dining room and who were reviewed	F 809	F809 □ Frequency of meals/HS snacks: " Meals are being served according to the posted schedule. " R128 is offered a beverage or a snack if seated in dining room early prior to the	10/2/18

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F 809	Continued From page 62 for dining services. Findings include: In the Cedar unit, the posted meal times were: -Breakfast: 8:20 a.m. -Lunch: 12:20 p.m. -Dinner: 5:00 p.m. There were 15 hours, 25 minutes between the posted dinner and breakfast times. R128's Admission Record dated 8/23/18, indicated R128 had diagnoses that included dementia with behaviors, anemia, and muscle weakness. R128's Order Summary Report, dated 8/23/18, indicated R128 was 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. R128's care plan dated 5/5/18, indicated R128 had lost weight during the last 3 years resulting in a body mass index (BMI) at the lowest of an acceptable range. R128 was to receive increased calorie foods and nutritional supplements at medication pass times. On 8/22/18, at 7:00 a.m. R128 was observed in her wheelchair, in the dining room of the Cedar unit. Continuous observations began on 8/22/18, from 7:47 a.m. until 9:22 a.m.	F 809	meal, or if there is a delay in mealtime. " R4, R118 and R128 are offered nourishing snacks at bedtime. " The process for offering, providing and documenting HS snacks has been reviewed and revised. " Nursing staff and Dietary staff have been educated on the HS snack system, and regarding facility expectation for offering nourishing snacks at bedtime. " Observational audits of HS snack process will be conducted by PM Nurse Supervisors two audits weekly x 4, then two audits every other week x2, then as directed by QAPI.	

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F 809	Continued From page 63	F 809		

On 8/22/18, at 7:47 a.m. R128 was observed in her wheelchair in the unit dining room. R128 was not seated at a table, and did not have coffee or juice. R128 was not approached, offered a beverage or an activity at any time. R128 continued to sit in her wheelchair, sometimes grinding her teeth until 8:59 a.m., when R128 was pushed in her wheelchair to at table near the window. R128 was still offered no beverage or food item. From 9:07 a.m. until 9:20 a.m., R128 was observed with her head forward as if dosing. At 9:22 a.m. a staff person sat down to assist R128 to eat her breakfast.

At no time was R128 offered coffee, juice, or a snack to tide her over until breakfast. R128 received her breakfast meal at 9:22 a.m., which is 57 minutes past the posted time of 8:25 a.m. for the Cedar Unit breakfast meal. This was 16 hours, 22 minutes after the posted dinner time for the Cedars unit.

Review of R128's Documentation Survey Report printed 8/23/18, indicated HS snacks are as needed (PRN). R128's documentation indicated she had 1 bedtime (HS) snack in June (but before supper), 1 HS snack in July (before supper), and none in August.

R4's Admission Record dated 8/23/18, indicated R4 had diagnoses that included unspecified dementia, Alzheimer's disease, and dysphagia (difficulty swallowing).

R4's quarterly Minimum Data Set (MDS) dated 5/3/18, indicated R4 had moderately impaired cognition.

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F 809	Continued From page 64	F 809		

R4's diet order dated 4/08/18,was for a low salt diet, low fat/cholesterol 3 gram sodium.

R4's care plan printed 8/16/18, indicated R4 was edentulous (no teeth), and received a pureed, low sodium, low fat, low cholesterol diet with honey (textured) liquids.

Evening snack records for R4 were requested but not received. The written request was returned with a notation that snacks consumed by R4 were not documented.

R118's Admission Record dated 8/23/18, indicated R118 had diagnoses that included hemiplegia and dysphagia.

R118's annual Minimum Data Set (MDS) dated 02/02/18, indicated R118 needed extensive assistance with eating with one person providing physical assistance.

R118's care plan dated 2/5/18, indicated R118 required extensive assist of one for all meals. The nutrition portion of the care plan included intervention of extensive hands-on assistance to total assistance, to finish the meal, and instruction to sit on R118's left side to assist.

R118's evening snack records from 7/1/18 - 8/22/2/18, were requested. Records provided indicated R118 ate an evening snack at 9:50 p.m. on 8/3/18. The Documentation Survey Report provided for July 2018, indicated that R118 ate one evening snack at 8:33 p.m. and 4 snacks between the hours of 10:00 p.m. and 6:00 a.m. for the month.

On 8/23/18, at 3:13 p.m. nursing assistant (NA)-J

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F 809	Continued From page 65	F 809		

stated usually if a resident stated they were hungry during the evening, she would give them something to eat. NA-J stated she would check for special diets, and look in the back room refrigerator to see if they had a labeled snack specifically for that individual. NA-J said she made an effort to give the labeled snacks, specific snack orders for example, for diabetics, to the recipients between 7-8 p.m. NA-J stated she knew who ate an evening snack by seeing them sitting outside their room eating, or if a resident couldn't feed themselves, she would stay with the resident and then record in the computer what was eaten for that snack.

On 8/23/18, at 3:13 p.m. licensed practical nurse (LPN)-L stated staff offer snacks of ice cream or juice to residents. LPN-L stated a lot of residents do not want an evening snack because supper ended around 6:00 p.m. She said the diabetic residents do get evening snacks, either specially labeled snacks, or staff offer a snack from the stock supply if there was not a specifically labeled snack. For residents that cannot answer, LPN-L would offer some extra pudding as part of the med passing process. LPN-L stated a lot of the residents are sound asleep by 8:00 p.m. so she felt lucky to get their medications to them. She stated a lot of the residents make statements they had three good meals and, "Oh, I'm eating again." LPN-L said the nursing assistants are the ones who record evening snack intakes.

On 8/23/18, at 2:07 p.m. dietary manager (DM) stated nursing staff record the evening staff intake. When asked to check evening snack intake for R118, she looked in R118's electronic health record and stated the last time staff recorded when R118 ate an evening snack was

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F 809	Continued From page 66 8/13/18. The facility policy Meal Times/Frequency dated 1/27/18, directed no more than 14 hours elapse between a substantial evening meal, and breakfast the following day unless a nourishing snack is offered to residents at bedtime. The policy directed the facility offer nourishing snacks, and offering such snacks allows there to be up to 16 hours between the evening meal and the following day breakfast meal. Nursing staff, per the policy, was responsible for offering an evening snack, and for documentation of the snack in the electronic record. The facility policy Hour of Sleep (HS) Snack dated 1/18, directed each resident would be offered an HS snack. The policy directed the facility would have snacks available, and make the residents aware of that availability. After supper snacks would be made available at the nursing station for each resident. Refusals of snacks were to be documented in the electronic record.	F 809		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adaptive eating equipment was provided for 1 of 1 residents	F 810	F810 □ Eating equipment/assistive devices: " The plan of care for R117 has been	10/2/18

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F 810	Continued From page 67 (R117) reviewed for nutrition. R117's Admission Record printed on 8/23/18, indicated R117's diagnoses included dysphasia (difficulty swallowing) and cancer of throat or lung. R117's admission Minimum Data Set (MDS) dated 5/4/18,indicated R117 had difficulty eating due to sequencing errors and declining coordination. The MDS further identified R117 required assistance with eating, required a mechanical soft consistency diet (chopped, ground, pureed foods, and foods that readily break apart without a knife). R117's goal listed was to work toward resident highest level of independence with eating. On 5/4/18 a Physical, Occupational and Speech Therapy form instructed: "Pt [patient] to use scoop plate [plate with elevated edges] at all meals." R117 was observed for meals on: 8/20/18, for the supper meal. 8/21/18, for the breakfast meal. 8/22/17, for the breakfast meal. The facility failed to provide the ordered scoop plate for any of those meals. On 8/23/18, at 8:25 a.m. registered nurse (RN)-H verified R117 had not had a scoop dish. On 8/23/18, at 9:20 a.m. the director of dietary services (DD) indicated the normal process was an order was called down to kitchen, dietary staff modifies the Adaptive Equipment list based on information they get from occupational therapy (OT). However, if OT was not involved the	F 810	reviewed in regard to assistive devices with eating, revised if indicated, and R117 is receiving the assistive device according to plan. " Other residents who are identified as needing special eating equipment or utensils are receiving this equipment or devices according to plan. " Nursing staff have been re-educated regarding the system for identifying assistive devices for eating, as well as the importance of ensuring these devices are provided according to plan. " Observational audits to monitor for compliance will be conducted by the nurse manager or designee two audits weekly x4, then two audits every other week x2, then as directed by QAPI.	

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F 810	Continued 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		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper drying and storage of stainless steel serving pans to prevent bacteria formation and potential for foodborne illness. This deficient practice had the potential to affect all 165 residents who ate food prepared in the facility kitchen. Findings include: On 8/20/18, at 1:27 p.m. during the initial	F 812	F812 □ Kitchen sanitation: " Stainless steel serving pans are thoroughly cleaned, properly air dried and stored to ensure they are not put away wet. " An additional drying rack was placed in the kitchen to expand drying space. " The policy for cleaning and properly air drying pots and pans has been reviewed and updated. " Dietary staff have been re-educated on	10/2/18

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F 812	Continued From page 69 observation of the kitchen with the dietary manager (DM), four stainless steel steam table pans were checked in the storage area near the pots and pans sink. Two of the pans had been put away wet. Two more stainless steel pans stored in the cooks area were also found to be stored wet. The DM verified the pans were put away to be used again, and stated the pans were to be air dried before being stacked for use. On 8/23/18, at 2:07 p.m. during a second observation of the kitchen, four stainless steel pans were checked on a storage shelf in the cooks area. Of the four pans, one pan was noted to be wet and another had been put away with food residue remaining on the pan surface. The DM verified the wet pans and the soiled pans.	F 812	the facility expectation for thoroughly cleaning, properly air drying and storing pots/pans so they are not put away wet. " Audits will be conducted by Dietary Director or designee 3 x weekly for 4 weeks, then 2 times weekly for 2 weeks, then one time a week for 2 weeks, then as directed by QAPI.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		10/2/18

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F 842	Continued From page 70 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 71 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain an accurate, and complete medical record related to resuscitation status for 3 of 36 residents (R72, R4, R118) reviewed for advanced directives. Findings include: R72's Admission Record printed 8/23/18, indicated R72's diagnoses included Alzheimer's disease, dementia, hypertension, and type 2 diabetes. R72's care plan dated 7/27/17, indicated R72 was severely cognitively impaired, and was able to communicate needs, with confusion increasing in the later day. R72's paper medical record included a Provider Orders for Life Sustaining Treatment (POLST) dated 12/18/17, signed by R72, which directed cardiopulmonary resuscitation (CPR). R72's electronic medical record, R72's profile page indicated DNR (Do Not Resuscitate), and the physician orders, dated 4/9/18, indicated an order for DNR.	F 842	F842 □ Medical Records: " The resuscitation code status conflicting information located in the electronic record for F72, R4 and R118 was removed during the survey. " All resident electronic records were reviewed to ensure there was no conflicting information present as compared to the POLST which is the source document for resuscitation status at Chris Jensen. " Licensed nurses and Health Unit Coordinators have been re-educated that the primary source of resuscitation information is the POLST. This POLST is signed by the resident/family, and also reviewed and signed by the physician. " In review of this process with the Medical Director, the POLST will remain the source document. The resuscitation status will not be entered as a physician order into the electronic record but will remain in the front of the hard copy chart. " Licensed nurses, TMAs, and Health Unit Coordinators have been re-educated regarding facility process of using the	

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F 842	Continued From page 72	F 842	POLST and the nurse team sheets as the source document and the quick identifier for resuscitation status. " Audits of consistent information regarding resuscitation status will occur weekly two audits x4 weeks, then two audits every other week, then as directed by QAPI. Audits will be conducted by the nurse managers.	

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F 842	Continued From page 73	F 842		

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F 842	Continued From page 74	F 842		

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F 842	Continued From page 75	F 842		

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F 842	Continued From page 76	F 842		

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F 842	Continued From page 77	F 842		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 94	F 842		

R4's Admission Record printed 8/23/18, indicated R4's diagnoses included dementia, Alzheimer's disease, acute kidney failure and chronic obstructive pulmonary disease.

R4's quarterly Minimum Data Set (MDS) dated 5/3/18, indicated R4 was cognitively impaired.

A review of R4's paper medical record included a POLST dated 7/30/18, and signed by a nurse practitioner 8/3/18, indicating R4's wish for his resuscitation status to be DNR.

A review of active orders in the electronic health record for R4 included an active order dated 4/8/18, for Full Code, and an active order dated 7/30/18, for DNR.

A review of the top of the page of R4's electronic

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	245366	A. BUILDING _____ B. WING _____	08/23/2018

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F 842	Continued From page 95	F 842		

health record indicated conflicting resuscitation status of DNR, Full Code.

A review of the team sheet indicated R4's code status to be DNR.

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 review of R118's paper medical record included a POLST signed by R188's wife (undated) which was also signed by a doctor on 5/7/15, and indicated R118's wish for resuscitation status to be Full Code.

A review of active orders in the electronic health record for R118 included an active order dated 4/8/18, for resuscitation status of DNR. DNR was also listed on the top page of the electronic health record.

A review of the team sheet indicated R118's resuscitation status to be CPR, and R118's care plan indicated code status of CPR with aggressive measures.

On 8/22/18, at 10:28 a.m. R118's wife, Family Member (FM)-E confirmed that they wanted R118 to have a Full Code status.

On 8/21/18, at 3:31 p.m. the director of nursing (DON) stated the team sheet that the nurse or trained medication aide (TMA) has on the medication cart has each resident's codes status,

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F 842	Continued From page 96 room number and miscellaneous information. The sheet that the NA's carry with them do not include the resident's code status. The DON stated the nurse manager verified the group sheet for correctness. If there were changes to the code status, the nurse manager make changes to the sheet. The team sheet gets updated as needed and/or upon admission. The facility policy CPR dated 7/18, directed each resident's choice regarding CPR or DNR code status was readily available for quick identification. The policy lacked where staff should access the code status information.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		10/2/18

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F 880	Continued From page 97 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 98 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand washing after peri cares for 2 of 4 residents (R4, R128) reviewed for bowel and bladder. Findings include: R4's quarterly Minimum Data Set (MDS) dated 5/30/18, indicated R4 had moderately impaired cognition, and was occasionally incontinent of bladder. R4's MDS also indicated he required extensive assistance with personal hygiene and toileting. On 8/23/18, at 7:43 a.m. nursing assistant (NA)-0 entered R4's room to offer breakfast and morning care. NA-O put on gloves prior to assisting R4 with washing his face, washing under arms, and peri areas. NA-O removed an incontinent pad that was wet with urine, and completed cares. Without removing the soiled gloves, NA-O assisted R4 in putting on a new gown, pulling up the comforter, changing the garbage, and adjusting the bed height using an electric control. After that, NA-O went into R4's bathroom and removed his gloves, and sanitized his hands. On 8/23/18 at 7:58 a.m., NA-O stated he did touch items after providing peri cares. NA-O stated they had been taught to wash hands after glove removal, but sometimes they forgot. R128's Admission Record printed 8/23/18,	F 880	F880 □ Infection Control " R4 and R128 are receiving cares that include proper hand washing and glove use. " Other residents are receiving cares that include proper hand washing and glove use. " Nursing staff have been re-educated regarding facility expectation for proper hand washing and glove use, including hand sanitizing between glove changes. " Observational check off regarding hand washing has been added to the orientation process for nursing staff. " Observational audits to monitor for compliance with hand washing and glove use expectations will be conducted by nurse managers or designee two audits weekly x4 weeks, then two audits every other week x2 weeks, then as directed by QAPI.	

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F 880	Continued From page 99	F 880		

indicated R128 had diagnoses that included dementia with behaviors, and muscle weakness.

R128's quarterly 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 toileting, and staff were to provide peri cares after any incontinent episode.

R128's care plan dated 5/5/18, indicated R128 had dementia with behaviors, history of a neurogenic bladder, and to provide peri cares after any incontinent episode.

On 8/22/18, at 9:36 a.m. NA-N wheeled R128 from the dining room to her bedroom to assist R128 onto the toilet. NA-N locked R128's wheelchair next to the toilet and put on gloves. NA-N assisted R128 to hold the grab bars with two hands, and using a transfer belt, assisted R128 to standing, then transferring and sitting on the toilet. After R128 urinated in the toilet, NA-N wiped R128's peri-area and assisted R128 in pulling up her pants. With the soiled gloves, NA-N moved the wheelchair position by using the handles, took off the transfer belt, and then removed the gloves. Without performing hand hygiene, NA-N flushed the toilet, rolled up the transfer belt and put it in her pocket, drew up the garbage bag, placed a new bag in the container, unlocked the wheelchair brakes, and used the bathroom door handle to open the door and push R128's wheelchair into the hallway. When NA-N got to the soiled utility room, she entered and washed her hands.

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F 880	Continued From page 100 On 8/22/18, at 9:45 a.m. NA-N stated she realized she forgot to wash her hands, and she had been taught to wash hands after glove removal. NA-N also stated that she was still touching "dirty" items so it made sense to wait until she was in the soiled utility room to wash hands. On 8/23/18, at 8:20 a.m. licensed practical nurse (LPN)-B stated the goal was if a staff person touched the patient, they washed or sanitized their hands. LPN-B reiterated, if staff have skin contact, no matter what, they wash their hands. Hands should be washed or sanitized after glove removal, then staff can go back and adjust clothing bed height, etc. On 8/23/18, at 12:21 p.m. the director of nursing (DON) stated she expected hands to be washed or sanitized immediately after glove removal.	F 880		

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	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/22/2018**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	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.

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Chris Jensen Health and Rehabilitation Center is a 2-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1974 & 85 an addition(s) was constructed to the building that was determined to be of Type II(111)construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building.	K 000		

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K 000	Continued From page 2 The building is fully sprinkler protected, by a complete automatic fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 170 beds and had a census of 160 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by:	K 341		10/2/18

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K 341	Continued From page 3 Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2012 NFPA 101, "The Life Safety Code" Sections 19.3.4.1 and 9.6, as well as 2010 NFPA 72, "National Fire Alarm and Signaling Code" sections 29.8.3.4. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affect 4 of 170 residents, as well as an undetermined number of staff, and visitors Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 08/22/2018, observation revealed, that the smoke detectors located in the corridor outside of the Administrators office was installed within 36 inches of a HVAC vent diffuser. This deficient condition was confirmed by a Maintenance Supervisor.	K 341	The smoke detector was moved 36" away from the air vent. The correction was completed on 8/22/2018. The Environmental Services Director was responsible for the completion of the work and is responsible for monitoring to prevent a reoccurrence of this deficiency.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00598	A. BUILDING: _____ B. WING _____	08/23/2018

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00598	A. BUILDING: _____ B. WING _____	08/23/2018

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/20/18, to 8/23/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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	00598	A. BUILDING: _____ B. WING _____	08/23/2018

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. 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. Findings include: R148's admission Minimum Data Set (MDS) dated 8/15/18, indicated diagnoses that included dysphagia (difficulty swallowing, traumatic brain injury (TBI) and muscle weakness. In addition, the MDS identified R148 received tube feeding. R148's Physician Order dated 8/8/18, indicated R148 had an order for Jevity 1.0 (nutrition for tube feeding), 65 milliliter (ml) per/hour for 21 hours continuously from 8:00 a.m. to 5:00 a.m. In addition, a physician order dated 8/9/18, indicated R148 was to receive 150 ml water flushes via gastrostomy (g) tube four times daily for a total of	2 300	corrected	10/2/18

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2 300	Continued From page 3 600 ml. R148's care plan dated 8/16/18, indicated R148 did not receive anything by mouth, and she received tube feeding. The care plan indicated 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 preparing R148's medications. RN-D crushed seven different medications in separate plastic bags and mixed two packets of powdered Potassium Chloride 20 milliequivalent (mEq) in five ounces of water. RN-D stated she was going to give all the medications via g-tube. At 8:11 a.m. RN-D arrived at R148's room, went to the bathroom and obtained 200 ml of water in a graduate cylinder. RN-D approached R148, indicated she was going to administer medications and start her enteral feeding via g-tube. RN-D pulled the bedside table and set down the small cup with Potassium Chloride mixed in water, and the rest of R148's morning medications crushed in little plastic bags. After applying gloves, RN-D was picked up the g-tube, removed the tab closure, and inserted a syringe with air into the feeding port as she listened with a stethoscope to check for tube placement. RN-D clamped the g-tube, took the syringe off the port, then separated the barrel and plunger. RN-D inserted the barrel into the g-tube port and administered 15 ml of water, clamped the g-tube, poured the Potassium Chloride liquid into the barrel and flushed with 10 ml of water. RN-D clamped the g-tube and poured another 10 ml of water into the barrel. RN-D emptied the crushed medication powder into the water in the barrel,	2 300		

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2 300	Continued From page 4 and released it to adminsitered the medications. RN-D followed this with a 10 ml flush of water. RN-D repeated this process of emptying the crushed powdered medications five times without mixing the medications with water before pouring them into the barrel. Once finished, RN-D went into the bathroom and obtained another 200 ml of water. RN-D returned to R148's bed side, and flushed the tube. RN-D continued to administer the crushed powdered medications on two separate occasions followed by water flushes. RN-D stated she had used a total of 350 ml of water to complete the water flushes. RN-D removed her gloves, dumped the remaining 50 ml of water, cleansed her hands, and left the room without starting R148's tube feeding. At 8:25 a.m. RN-D reviewed R148's physician orders and verified R148 was to receive 150 ml of water flushes four times a day. RN-D stated she had given R148 more water because she had a problem with medications not draining, and she was going to hold off the tube feeding "To let the medications settle." RN-D stated she had not mixed the medications prior to administering them, because she had asked RN-E, who told her she would pour the powder into the syringe barrel with water 5 ml to 10 ml of water, and then follow with a water flush of the same amount. RN-D stated she did not know the policy on tube feeding, and that was why she had asked RN-E. RN-D further stated she was going to hold off on starting the tube feeding. On 8/22/18, at 1:40 p.m. RN-F verified RN-D had not demonstrated competency skills related to medication administration through a g-tube. RN-F stated all the licensed nursing staff had a clinical check list. RN-F stated both LPN's and RN's had the same clinical requirements in the checklist.	2 300		

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2 300	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure competent staffing. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300		
2 575	MN Rule 4658.0430 Subp. 1 Health Information Management Service 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to maintain an accurate, and complete medical record related to resuscitation	2 575	corrected	10/2/18

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2 575	Continued From page 6 status for 3 of 36 residents (R72, R4, R118) reviewed for advanced directives. Findings include: R72's Admission Record printed 8/23/18, indicated R72's diagnoses included Alzheimer's disease, dementia, hypertension, and type 2 diabetes. R72's care plan dated 7/27/17, indicated R72 was severely cognitively impaired, and was able to communicate needs, with confusion increasing in the later day. R72's paper medical record included a Provider Orders for Life Sustaining Treatment (POLST) dated 12/18/17, signed by R72, which directed cardiopulmonary resuscitation (CPR). R72's electronic medical record, R72's profile page indicated DNR (Do Not Resuscitate), and the physician orders, dated 4/9/18, indicated an order for DNR. R4's Admission Record printed 8/23/18, indicated R4's diagnoses included dementia, Alzheimer's disease, acute kidney failure and chronic obstructive pulmonary disease. R4's quarterly Minimum Data Set (MDS) dated 5/3/18, indicated R4 was cognitively impaired. A review of R4's paper medical record included a POLST dated 7/30/18, and signed by a nurse practitioner 8/3/18, indicating R4's wish for his resuscitation status to be DNR. A review of active orders in the electronic health record for R4 included an active order dated	2 575		

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2 575	Continued From page 7 4/8/18, for Full Code, and an active order dated 7/30/18, for DNR. A review of the top of the page of R4's electronic health record indicated conflicting resuscitation status of DNR, Full Code. A review of the team sheet indicated R4's code status to be DNR. 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 review of R118's paper medical record included a POLST signed by R188's wife (undated) which was also signed by a doctor on 5/7/15, and indicated R118's wish for resuscitation status to be Full Code. A review of active orders in the electronic health record for R118 included an active order dated 4/8/18, for resuscitation status of DNR. DNR was also listed on the top page of the electronic health record. A review of the team sheet indicated R118's resuscitation status to be CPR, and R118's care plan indicated code status of CPR with aggressive measures. On 8/22/18, at 10:28 a.m. R118's wife, Family Member (FM)-E confirmed that they wanted R118 to have a Full Code status. On 8/21/18, at 3:31 p.m. the director of nursing	2 575		

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2 575	Continued From page 8 (DON) stated the team sheet that the nurse or trained medication aide (TMA) has on the medication cart has each resident's codes status, room number and miscellaneous information. The sheet that the NA's carry with them do not include the resident's code status. The DON stated the nurse manager verified the group sheet for correctness. If there were changes to the code status, the nurse manager make changes to the sheet. The team sheet gets updated as needed and/or upon admission. The facility policy CPR dated 7/18, directed each resident's choice regarding CPR or DNR code status was readily available for quick identification. The policy lacked where staff should access the code status information. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure information in the medical record is correct. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 575		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient	2 800		10/2/18

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2 800	Continued From page 9 number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate staff to provide care for residents on the Cedar Unit. This had the potential to affect all 40 residents residing on the unit. Findings include: On 8/20/18, at 4:54 p.m. the food arrived in the Cedar dining room for the evening meal. Staff did not finish serving the the meal until 6:15 p.m. The evening meal was scheduled for 5:25 p.m. R35's 14 day Minimum Data Set (MDS) dated 7/10/18, indicated he was moderately cognitively impaired, and required assistance for transfers and toileting. During interview on 8/20/18, at 6:28 p.m. R35 stated he had a challenge getting up for breakfast in the morning. He stated he did not like eating in bed, and sometimes the facility was understaffed and he missed breakfast. He stated this had happened recently. A review of a device activity report dated 8/19/18, indicated R35's call light was on 8/18/18, at 7:14 a.m. and was not answered until 8:32 a.m. a total of 1 hour and 20 minutes. On 8/19/18, R35's call	2 800	corrected	

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2 800	Continued From page 10 light was turned on at 7:05 a.m. and not answered until 7:39 a.m. a total of 34 minutes and 11 seconds. R69's quarterly MDS dated 6/14/18, indicated he had intact cognition, and required extensive assitance with all activities of daily living. During an interview with R69 on 8/20/18, at 1:59 p.m. family member (FM)-B stated she was at the facility a lot. FM-B stated R69's call light took a long time to be answered, and stated sometimes it went for up to 25 minutes without being answered. R69 stated he almost always had to go to the bathroom in his pants. R95's annual MDS dated 7/25/18, indicated he was severely cognitively impaired, and required extensive assistance with all activities of daily living. The MDS further indicated it was very important to R95 that he was able to participate in his favorite activities. R95's care plan dated 7/26/18, identified dementia with behavioral disturbance, and directed staff to anticipate and met his needs, offer choices regarding daily care and reorient as needed. The care plan further identified behaviors that included: easily frustrated, especially when R95 could not hear, or staff did not respond quickly and directed staff to check for hunger, thirst, pain or activity needs. During an observation on 8/22/18, at 7:05 a.m. R95 was in his wheelchair self-propelling around the dining room. At 7:12 a.m. R95 was in front of the nurses station desk requesting to call his brother. Licensed practical nurse (LPN)- B told R95 to give him a little bit, and he would find the number for him. At 7:21 a.m. R95 was propelling himself down the hallway. A staff member pushed him back into the dining room where a television	2 800		

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2 800	Continued From page 11	2 800		

was on, turned to a talk show. At 7:39 a.m. R95 was again propelling himself in the dining room. At 7:46 a.m. R95 attempted to exit the unit via an open elevator door. Registered nurse (RN)-B intervened and told him he needed his hearing aides. R95 asked RN-B who she was and called her a name. At 7:50 a.m. R95 was again escorted back a table in the dining room by a staff member, but was not offered anything to eat or drink. There was nothing on the table except a linen napkin and a box of tissues. R95 began emptying the box of tissues onto the table At 8:05 a.m. R95 propelled himself away from the dining room table. At this time, a radio was playing tuned to a country station, three other men were sitting at the table but no one was talking. Three other residents were sitting in the dining room with their eyes closed, a fourth resident was sitting in a wheel chair with her hands covering her face and another resident sat alone at a table with her arms crossed in front of her. There was no attempt by staff to engage R95 or the other resdients during the observation. At 8:18 a.m. R95 made another attempt to exit the unit through the elevator door. Staff again intervened and did not allow him to leave. R95 pushed the elevator button again and a staff member brought him back to his table in the dining room and walked away. At 8:23 a.m. R95 propelled away from the table and headed back to the elevator. At 8:25 a.m. the elevator door opened and R95 attempted to exit but his wheel chair was stuck on the wall preventing him from moving. At 8:27 a.m. the elevator door opened again and R95 again attempted to get in. A staff member brought him back to the table in the dining room. At 8:33 a.m. R95 threw a napkin on the floor. A resident seated at the table picked up the napkin and gave it to R95. R95 threw the napkin under the table a second time and attempted to stand up out of the

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2 800	Continued From page 12 wheel chair to pick it up. At 8:36 a.m. R95 attempted to get out of his wheel chair to pick up the napkin. While trying to kneel on the floor, R95 fell onto his right side on the floor. On 8/22/18, at 9:13 a.m. staff began serving the breakfast meal on the unit. The meal was scheduled to begin at 8:00 a.m. R11's annual MDS dated 5/23/18, indicated he was cognitively intact, and required extensive assistance for bed mobility, toileting, and transfers. The MDS further indicated R11 was always continent of bowel and bladder. . On 8/21/18, at 2:37 p.m. R11's family member (FM)-C stated she visited the facility daily. FM-C stated she had gone to LPN-B several times about the call light system. She stated R11 knew how long his call light stayed on, and stated she felt like it affected his quality of life when he had to wait to use the bathroom. FM-C stated staff assisted R11 to the bathroom, and said they would watch for the call light, but would not answer it. FM-C stated if R11 had to wait too long for his call light to be answered he would bang on the bathroom wall. FM-C stated it was disheartening when she got to the facility and another residents told her R11 was banging on the wall. FM-C further stated she had asked LPN-B not to assign the new staff to R11, because she ended up having to train them in and stated, "That's not my job." R48's annual MDS dated 6/20/18, indicated he was moderately cognitively impaired, required extensive assitance from two staff for bed mobility, transfers, and toileting. The MDS also indicated R48 was always incontinent of bowel and bladder.	2 800		

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2 800	Continued From page 13 On 8/22/18, at 1:46 p.m. R48's family member (FM-D) stated she did not feel her R48 was safe when she was not at the facility. FM-D stated R48's face was never washed, and his teeth were never brushed. FM-D stated one day she arrived at the facility to find R48 hanging out of bed and lying in a urine soaked incontinence brief. FM-D stated the weekends were "horrible," and stated another day she had come to the facility, and R48's bed had urine soaked sheets under the comforter. FM-D stated she had concerns about a specific staff member, and had spoken to LPN-B several times about her concerns. FM-D stated she felt like there was a lack of staff, and a lack of competent staff on the unit, and stated no one was overseeing the staff on the unit. FM-D further stated there were not enough staff to get everyone up to a meal in time. On 8/22/18, at 7:41 a.m. LPN-C stated although there were five NA's working on the unit that morning, there were usually only four. LPN-C also stated she was the third nurse on the unit that morning and stated that also wasn't typical. LPN-C stated the facility did not schedule staff by acuity and stated, "It's hard, I almost never get a break." On 8/22/18, at 1:27 p.m. RN-B stated there were usually four NA's scheduled on the unit and two nurses. RN-B stated it was typical to serve breakfast at 9:00 a.m. RN-B stated although there were several additional staff in the dining room that day, they were not usually there. On 8/22/18, at 1:34 p.m. LPN-B stated the facility staffed based on census. He stated when the unit had 40 residents the facility would schedule an additional aide for four hours. LPN-B stated if the	2 800		

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

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census dropped to 39 there were four NA's scheduled. LPN-B stated there was no change in the staffing levels if acuity increased. LPN-B stated he had received complaints from families related to long call light wait times, had concerns from a few residents, and had heard in general, staff felt like they needed more help. He stated the longer call light times were generally around meal times.

A review of facility Grievance Forms identified the following:

5/8/18, R11 reported he had a "rough few days." He reported call light wait times of 30 minutes and reported being left on the toilet for 30 minutes. FM-C stated she felt like R11 only received care when she was in the facility to look after his needs. The report indicated LPN-B spoke with staff and explained the call lights were important, and they needed to work as a team to prevent long call light wait times.

6/13/18, R150 reported call lights took too long to be answered. The report indicated a call light audit was performed, and R150 had a legitimate complaint. Call lights were on longer than the facility would like. The report indicated LPN-B spoke with staff on importance of call lights, and indicated facility would work with staff to come up with better options to meet resident needs.

8/2/18, R122 reported his call light was not being answered in the afternoon. R122 reported he had to wait 45 minutes, and stated sometimes staff did not come at all. A call light audit was performed and identified a wait time of over 27 minutes on 7/31/18.

8/16/18, R77 reported the NA's always tell her

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they are too busy to help her. A section of the form labeled Grievance Resolution indicated R77 stated she did not remember saying this, and stated it could have been from another unit as she had recently moved. The grievance form indicated grievance not confirmed and no action taken.

During interview on 8/23/18, at 10:29 a.m. R77 stated, "I do remember saying that, it tends to be on the true side."

On 8/23/18, at 1:20 p.m. LPN-B stated he recalled a concern about a staff member from FM-C. LPN-B stated the concern was that the staff member didn't know R11 well, and felt there was a lack of consistency in staffing. LPN-B stated when a family member came to him with a concern he would try to address it and correct it right away if he could. He stated he would talk to the employee, but would not necessarily document the conversation. LPN-B did not recall a concern about the NA by FM-D.

On 8/23/18, at 3:01 p.m. the human resources director (HRD) and the director of nursing (DON) were interviewed. The HRD stated staff met every morning to discuss census, potential admissions, and acuity changes. The HRD stated if staff expressed concerns related to staffing levels, she encouraged them to go to the nurse manager or team lead. The DON stated the nurse managers were responsible for following up on staffing concerns by residents, families and staff. The DON stated concerns were documented and audited to ensure follow up. In regard to the meals running late on the units, the DON stated meals were running late on units because NA's are still getting people up. She stated she was aware they were a little late, but did not realize it

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2 800	Continued From page 16 was typical to be routinely late. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure there is enough staffing on each unit to ensure that resident's needs are met. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement identified	2 830	corrected	10/2/18

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2 830	Continued From page 17 interventions to reduce the risk for falls for 2 of 6 residents (R95, R13). In addition, the facility failed to conduct ongoing comprehensive assessment of falls to determine causal factors to reduce the risk for falls for 3 of 6 residents (R95, R147, R26) reviewed for accidents. Findings include: R95's annual Minimum Data Set (MDS) dated 7/25/18, indicated diagnoses that included dementia, Parkinson's disease and diabetes. The MDS also indicated R95 was severely cognitively impaired, required extensive assistance for all activities of daily living (ADLs) and was frequently incontinent of bowel and bladder. R95's care plan identified a risk for falls related to confusion and balance problems, and indicated R95 was unaware of safety needs. On 8/22/18, R95 was continuously observed from 7:05 a.m. until 8:33 a.m. At 7:05 a.m. R95 was observed sitting in his wheelchair, self-propelling around the dining room. At 7:12 a.m. R95 was in front of the nurse's station desk requesting to call his brother. Licensed practical nurse (LPN)-B told R95 to give him a little bit, and he would find the number for him. R95 was observed to have a fading yellow bruise on his forehead. R95 started propelling himself down the hallway. A staff member pushed him back into the dining room, where a television was on to a talk show. R95 was propelling himself in the dining room. At 7:46 a.m. R95 attempted to exit the unit via an open elevator door, registered nurse (RN)-B intervened and told R95 he needed his hearing aids. R95 asked RN-B who she was and called her a name. R95 was again escorted back to a table in the dining room by a staff member, but was not offered anything to eat or drink. A linen napkin	2 830		

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2 830	Continued From page 18	2 830		

and a box of tissues were on the table. R95 began emptying the box of tissues onto the table. R95 then propelled himself away from the dining room table. At this time, a radio was playing a country station, and three other men were sitting at the table, but no one was talking. Three other residents were sitting in the dining room with their eyes closed, a fourth resident was sitting in a wheel chair with her hands covering her face, and another resident sat alone at a table with her arms crossed in front of her. There was no attempt by staff to engage R95 or the other residents during the observation. At 8:18 a.m. R95 made another attempt to exit the unit through the elevator door. Staff again intervened, and did not allow him to leave. R95 pushed the elevator button again, and a staff member brought him back to his table in the dining room and walked away. R95 propelled away from the table and headed back to the elevator. At 8:25 a.m. the elevator door opened, and R95 attempted to exit but his wheel chair was stuck on the wall preventing him from moving. At 8:27 a.m. the elevator door opened again, and R95 again attempted to get in. A staff member brought him back to the table in the dining room. At 8:33 a.m. R95 threw a napkin on the floor. A resident seated at the table picked up the napkin and gave it to R95. R95 threw the napkin under the table a second time and attempted to stand up out of the wheel chair to pick it up. While trying to kneel on the floor, R95 fell onto his right side on the floor. LPN-C responded to the fall and stated to R95, "You did that on purpose didn't you?" LPN -C then stated to another staff member, "He so did that on purpose." LPN-C then turned to R95 and again asked him why he put himself on the floor. R95 remained lying on the floor. LPN-C stated to R95, "You threw yourself on the floor, why did you do that?" At this time, R95 remained on the floor

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2 830	Continued From page 19	2 830		

with five staff members standing over him. R95 displayed signs of agitation. R95 attempted to hit staff and squeezed LPN-C's hand, pointed at her with the other hand and stated, "It was you." The certified nurse practitioner walked over to where R95 was lying, and asked what happened. LPN-C stated R95 put himself on the floor, and stated he had been wild all night, throwing things and trying to punch staff. During the observation there were no attempts by staff to offer R95 fluids, food, toileting or any staff or activity engagement.

A review of facility documents identified the following:

A Resident Incident Report dated 7/30/18, indicated R95 was holding onto a fire door bar, stood up and slid to the floor. The report indicated R95 had numerous falls, and had impulse control issues. An interdisciplinary team (IDT) Root Cause Review dated 8/1/18, indicated a walking program to help with impulse control was initiated, and R95 was to be moved closer to the nurses station when a room became available.

A Resident Incident Report dated 7/31/18, indicated R95 was found sitting on his fall mat with his arm and elbow still on the bed on pressure pad alarm. The report indicated an extensive fall history, impulse control, and poor judgement. An IDT Root Cause Review dated 8/1/18, indicated consider walking program to see if it helps.

A Resident Incident Report dated 8/3/18, indicated R95 was found on the floor mat sitting on his buttocks and leaning on his left side against the bed. The report indicated a tabs alarm was placed, and indicated R95 had a history of manipulating alarms. An IDT Root Cause Review

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2 830	Continued From page 20 indicated R95's pressure alarm was removed, and replaced with a tab alarm. A Resident Incident Report dated 8/8/18, indicated R95 was attempting to sit up from his wheelchair, and another resident attempted to assist, causing R95 to fall. An IDT Root Cause Review dated 8/10/18, indicated occupation therapy to screen for wheelchair positioning, and a need for new anti-rollbacks for wheel chair. A progress note dated 8/11/18, indicated R95 was witnessed putting himself on the floor beside his wheel chair. A Falls Risk Post - Fall Assessment dated 8/14/18, indicated R95 was at the nurse's station and sustained a fall. An IDT Root Cause Review dated 8/14/18, indicated the facility was currently working on medication review with R95's provider, and discussed discontinuation of Seroquel. A progress note dated 8/15/18, indicated R95 was wide awake, was put back to bed, but tried numerous times to throw himself out of bed. When staff attempted to reposition R95, he was hitting, kicking, and punching. A progress note dated 8/21/18, indicated R95 was aggressive on night shift, and tried to put himself on the floor. R95 was lowered to the floor safely by staff. A progress note dated 8/22/18, indicated staff witnessed R95 stand up from his wheel chair and lay himself down on the floor. R15's incontinence brief was noted to be wet at the time. R95 sustained an abrasion measuring 4 centimeters (cm) x 1.5 centimeters to his middle back from	2 830		

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2 830	Continued From page 21 rolling himself around on the floor. A Resident Incident Report dated 8/22/18, indicated R95 fell while sitting in the dining room in his wheelchair with his tabs alarm on. A correlating progress note dated 8/22/18, indicated R95 was propelling himself all over the dining room, and put himself on the floor to "get attention." On 8/23/18, at 9:49 a.m. nursing assistant (NA)-B stated R95 would put himself on the floor and stated staff keep him by the nurses station because he will "pop" himself out of bed and onto the floor. NA-B stated she did not know if R95 comprehended what staff were saying or not, but stated R95 could understand simple cues. NA-B stated if staff asked R95 what he wanted he could sometimes tell them. NA-B stated staff put R95 by the nurse's station, but he got mad when staff kept him there, and that would lead to behaviors. On 8/23/18, at 10:15 a.m. LPN-D stated the last couple of times she worked R95 tried to push himself out of his chair. LPN-D stated R95 would roll out of bed. LPN-D stated R95 thought he was in jail at the facility, and did not understand he was there to stay. LPN-D stated R95 would say nobody was paying attention to him. On 8/23/18, at 10:33 a.m. LPN-B stated after a fall occurs, the nurse will come up with a short term intervention, then he would review the information and review what was done in the past. LPN-B stated falls were discussed in an IDT meeting, and the team discussed what was working on other units, discussed interventions, and initiated or changed interventions. LPN-B stated R95 had a significant history of falls, and there were numerous interventions in place.	2 830		

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2 830	Continued From page 22 During an interview on 8/23/18, at 11:01 a.m. family member (FM)-A stated R95 told him he has laid in bed for hours and no one would show up. FM-A stated falling was how R95 got them to pay attention. During a subsequent interview on 8/23/18, at 2:02 p.m. R95's falls were reviewed with LPN-B. LPN-B stated the intervention on 7/24/18, was to continue with the current intervention of an alarm. Regarding the falls on 7/30/18, and 7/31/18, LPN-B stated there was no documentation to indicate whether or not the walking program implemented as an interventions was being attempted by staff, and he did not know if they were doing it. LPN-B stated the occupational therapy assessment initiated following the fall on 8/14/18, (in which another resident was attempting to assist R95 to stand) was due to a need for new anti-rollbacks for the wheel chair. In regards to the 8/14/18, intervention which indicated the provider was to review R95's Seroquel, LPN-B stated the Seroquel order had not been adjusted until 8/22/18, and was discontinued when R95 admitted to hospice. R13's annual MDS dated 5/24/18, indicated diagnoses that included dementia, and diabetes. The MDS further identified R13 was severely cognitively impaired, required extensive assistance with ADLs, and was frequently incontinent of bowel and bladder. R13's care plan dated 5/24/18, identified a risk for falls related to dementia, bowel and bladder incontinence, and behaviors with impulsiveness. The care plan directed staff to use gripper socks in bed, keep the bed at a seated height, and re-direct when agitated. The care plan also	2 830		

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2 830	Continued From page 23 identified the use of a scoop mattress, offers to get up on overnight last rounds, and anti-skid mattress at bed side. Further, the care plan indicated staff to assist with toileting, but did not identify a frequency. On 8/22/18, at 7:51 a.m. R13 was observed sitting in her wheelchair. R13 had auto locking brakes on her wheelchair, and was propelling herself up and down the halls on the unit. Review of facility documents identified the following falls: A Resident Incident Report dated 5/17/18, indicated R13 was found on the floor in the doorway of her room. The report indicated a history of falls. An IDT Root Cause Review dated 5/21/18, indicated staff were to offer to get R13 up after nap during the day. A Resident Incident Report dated 6/4/18, indicated R13 was found sitting up next to her bed. An IDT Root Cause Review dated 6/6/18, indicated staff were to offer to get R13 up at 7:00 a.m. A Resident Incident Report dated 6/30/18, indicated R13 was found sitting against her bed on the floor. An IDT Root Cause Review dated 7/2/18, indicated staff were to check on R13 at last overnight rounds, and offer to get her up. A Resident Incident Report dated 8/8/18, indicated R13 was found sitting on her bed and slid off as staff approached, landing on the floor. A IDT Root Cause Review dated 8/8/18, indicated an anti-skid mattress was placed on the floor next to R13's bed.	2 830		

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2 830	Continued From page 24 A Resident Incident Report dated 8/11/18, indicated R13 was found sitting next to her bed supporting herself with one arm. An IDT Root Cause Review dated 8/13/18, indicated a six day sleep study was to be implemented. On 8/23/18, at 1:27 p.m. LPN-B stated a sleep study was initiated on 8/13/18, to determine a pattern for R13 however, the sleep study was not completed by staff. LPN-B further stated there had been no follow-up with the night shift to determine if R13 was getting up on the overnight shift or not. On 8/23/18, at 2:56 p.m. the director of nursing (DON) stated the IDT met every Monday to discuss falls. The DON stated the IDT discussed the time of day the falls occurred, whether the resident was hungry, thirsty or if they needed to use the bathroom. The DON stated the team also discussed effectiveness of the interventions, and if changes were needed. The DON stated the nurse manager was responsible for following up on fall interventions. R147's Admission Record printed 8/23/18, identified R147's diagnoses included dementia, difficulty in walking, tremor, and repeated falls. R147's admission MDS dated 1/4/18, indicated R147 had severe cognitive loss, received psychoactive medications, was frequently incontinent of urine, and required extensive assist with toileting. The MDS further identified R147 had falls with injury prior to admission, but no falls since admission. R147's ADLs care plan dated 1/8/18, indicated R147 required extensive assistance of 1-2 staff with a walker for ambulation. A hand written note on the care plan dated 1/25/18, indicated R147 refused assistance with ambulation, or to use	2 830		

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2 830	Continued From page 25 walker. A 2/13/18, hand written note indicated R147 was independent on the unit, and was to toilet upon rising, before and after meals, bedtime and as needed. Staff were directed to offer to toilet R147 every four hours on the night shift. A hand written note dated 6/8/18, directed staff to offer rest period with fluids and snacks. An 8/6/18, hand written note directed staff to offer to lay down after lunch. An 8/9/18, hand written note indicated no ambulation, transfer with assist of 1-2, stand pivot weight bearing as tolerated. R147's Safety/Falls care plan dated 1/8/12, directed use of a wheelchair, call light in easy access, check for unmet toileting needs, pain, etc., ensure environment is free from clutter, fall review facility protocol, reinforce need to use the call light to request assistance, and secure or locked placement. On 1/30/18, hand written note indicated nonskid footwear (gripper socks) were added. On 2/7/18, a note directed to offer to lay down after lunch. A note dated 2/13/18, indicated resident frequently noncompliant with offered rest periods. On 3/6/18, a hand written note indicated to redirect to sit down in dining room as resident allows, offer rest period with sweets. On 8/6/18, a hand written note indicated place abduction wedge between resident's legs at meal times as tolerated. On 8/8/18, a hand written note indicated a pad alarm to wheelchair. Review of the R147's progress notes indicated the following falls: On 1/26/18, at 12:46 a.m. Found crawling on hands and knees on the floor in the doorway to her room. Had been toileted and helped into bed at 11:00 p.m. Stated her knee gave out. No red areas noted, no swelling or obvious deformities. Very pleasant and cooperative. Confused conversation per normal but was smiling. Assisted up and walked to bed, denied having to use bathroom first, but then said she had to go.	2 830		

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2 830	Continued From page 26 Assisted to toileting. On 1/27/18, at 6:13 p.m. Resident had witnessed fall at 5:40 p.m. in hallway. Resident walking unsteady and agitated. Would not allow staff to assist in any way. Resident angry and carrying a knife. Resident fell onto left side and would not allow any assistance or vitals to be taken. Resident immediately stood up on own and began walking again; did not hit head. Knife fell out of resident's hand and was quickly removed from area by staff. Writer spoke with husband to notify of fall and agitation On 1/29/18, at 3:33 p.m. Resident had a witnessed fall on a.m. shift at approximately 1:25 p.m., she was walking backwards and fell with her back landing into another residents wheelchair. She then refused to have any vitals done, was having aggressive behaviors. Then got up off the floor with minimal help from staff, refused help. Sat in her w/c for a while, and then moved into one of the dining hall chairs and has been sitting there. As she was sitting there she was saying aggressive things towards staff, and other residents. No complaint of pain, did have Tylenol at approximately 1:40 p.m. Will continue to monitor for injury, but no apparent injury at this time. On 2/25/18, at 11:50 a.m. Resident found sitting on buttocks on the floor in the dining room with the back against the wall in between two chairs, a tray table was located in front of the chair to the left of the resident. When asked what happened, the resident stated, "I tried to sit down on the table and I sat down on the floor." Fall was unwitnessed, neurological assessments started and remained at resident's baseline. Resident did complain of a slight discomfort in left forearm area, no injury/redness/bruising noted. The pain went away within 5 minutes, resident stating, "I took my medications this morning." Resident	2 830		

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	00598	A. BUILDING: _____ B. WING _____	08/23/2018

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2 830	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 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 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 started on Risperidone 0.25 milligrams (mg) mg twice 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 and was also treated for a urinary tract infection. It is also noted that since the start of Risperidone, resident had had 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 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 was pushed by another resident into the wall hitting her head and falling to the floor. Observed	2 830		

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2 830	Continued From page 28 by staff who reported that she noticed that resident "was not responsive for a minute." This writer responded immediately as a large noise was heard from incident. Resident was found lying on her right side in the hallway, but was responsive to staff when this writer approached resident. 5 x 5 centimeter (cm) bump observed on the right side of resident head. No other injuries observed. Neuro checks started per policy. Some initial mild weakness in extremities noticed, but 15 minutes later resumed to baseline. Resident assisted up off the floor two times, and walked down to the dining room. Ice pack was applied to resident head for 20 minutes. Denies any pain. Resident able to follow commands and ate a good dinner. DON [director of nursing], RN [registered nurse] manager, on-call provider and family notified of incident. No new orders. Will continue to monitor for signs and symptoms of concussion or injury. Resident was later observed to walking around the unit socializing with staff and other resident appropriately. On 4/22/18, at 2:20 p.m. Patient was ambulating in dining area and fell backwards due to a push from another resident. No apparent injury and patient. Resident didn't hit her head, this was a witnessed fall. Writer spoke to Chris Jensen manager on call and patient's husband in regards to incident. Faxed incident report left in Doctors rounding book. Neuro status intact-will continue to observe. On 4/27/18, haloperidol (Haldol, an antipsychotic medication) was discontinued to see if it was causing/contributing to falls. On 5/8/18, 11:00 a.m. Falls Risk Post Fall Assessment indicated the following. R147 had a fall that occurred in end lounge room. Wearing nonskid footwear, underlying diseases or conditions: psychiatric or cognitive conditions, orthopedic/joint/arthritis, seizures. Takes	2 830		

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2 830	Continued From page 29	2 830		

psychotropic, anti-seizures. Functional status: unsteady at times, receiving rehab, occasional incontinence of bladder, self-toilets at times. Dementia. Was pushed by another resident.
On 5/8/18, at 11:00 a.m. an IDT Root Cause note indicated R147 was in lounge, and another resident pushed resident to floor, and she landed on her side. Resident did not hit head, and no injury at time of incident. Fall was witnessed by visitors. Causative factors: repeated falls, muscle weakness, disorientation unspecified. IDT determined root cause of fall to be pushed by another resident.
On 6/7/18, at 6:08 p.m. Kitchen staff found resident lying on floor. Staff intervention: assessment, neuro checks, moved all extremities, complaint of pain directly above left breast and below left breast. No injuries noted. Call to family/MD with notification.
On 6/7/18, at 5:15 p.m. a Falls Risk Post Fall Assessment: Fall indicated R147 had an unwitnessed fall, prior to ambulating in hall. Current interventions: safety monitoring, encourage resident to rest. Psychiatric or cognitive issues: use of psychotropic medication and anti-seizure medication. Functional status: leans to right when tired and ambulating. IDT Root Cause 6/8/18, for fall on 6/7/18, at 5:15 p.m. Resident found on floor in dining room. Causative factors: weakness/unsteady gait, dementia. IDT determined root cause of fall to be: ambulating on unit. New/Different period interventions now in place related to root cause: offer rest period with fluids and snacks. On 6/15/18, R147's psychiatrist notes indicated, "Major neurocognitive disorders due to known physiological condition, history of traumatic brain injury at age of 5, progressive cognitive decline likely Alzheimer's. Now with physical aggression and agitation along with delusional statements

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2 830	Continued From page 30 and thoughts. Milk [sic] increase in agitation now resolved, controlled. Anxiety disorder, psychotic disorder with delusions, and significant paranoia causing agitation and aggression. 'Well controlled with current therapy.' High risk medication use on psychotropic, monitoring weight, screening for movement issues on a monthly basis. Monitoring for sedation and falls benefits of anti-psychotic medication currently out weight risks. Will reevaluate medications on a monthly basis and attempt taper as appropriate." On 6/28/18, at 6:46 Writer notified by TMA [trained medication aide] that resident had a fall at 12:30 a.m. in bathroom doorway, sitting up on buttocks trying to get up. Noted red spot above upper left eyebrow. Fall unwitnessed. Resident unable to tell nurse what she was trying to do prior to event due to poor cognition. Doctor on call notified regarding injury to head. Resident in no acute pain and helped back into bed with Neuro's and vital signs started. Day nurse to notify family and manager. A Falls Risk Post Fall Assessment: for the fall 6/28/18, at 12:30 a.m. indicated R147 was in the bathroom, trying to use bathroom. Injury: red mark. Fall interventions currently being used. Gripper socks, bed low position, frequent vital signs, toilet. Underlying causes: psychiatric or cognitive, seizures/tremors, medications Psychotropic, anti-seizures, functional status: mobility issues, cognitive issues. Resident found in bathroom doorway sitting on butt, trying to get up. No apparent injury, six day bowel and bladder study. On 6/28/18, IDT Root Cause for the fall on 6/28/18, at 12:30 a.m. indicated resident found in bathroom door way sitting on butt, trying to get up. No apparent injury. Unsteady gait, disorientation, repeated falls. IDT determined root cause to be: wanting to use the toilet. New/different interventions now in place related to	2 830		

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2 830	Continued From page 31 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. R147 returned to the facility on 7/31/18. On 8/2/18, at 11:10 p.m. Resident had unwitnessed fall in bedroom next to bed on 8/2/18, at 3:30 p.m. Resident was attempting to transfer self to bed. Resident had been toileted about five minutes prior. Surgical incisions	2 830		

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2 830	Continued From page 32	2 830		

appeared intact and resident was able to move right hip joint with no signs of pain or impingement. Neuro checks started per policy due to fall being unwitnessed. Physician notified and attempted to notify family (unable to leave message as there is no answering machine). Will pass to next shift. A Falls Risk Post Fall Assessment dated 8/6/18, for fall 8/2/18, at 15:30-fall occurred in bedroom, attempting to transfer self to bed. No injury current fall intervention Low bed, 3 or more falls in the past six months: underlying conditions psychiatric, orthopedic/joint/arthritis. psychotropic medications, anti-seizures, antihistamines. Functional Status: unsteady gait, wheelchair, No safety awareness, not able to communicate needs, change in pain level (recent fractured hip). Resident attempting to self-transfer. 15 minute safety checks and continue low bed. On 8/6/18, the IDT Root Cause Review (for fall 8/2/18 at 15:30 p.m.) indicated: Prior to fall resident had unwitnessed fall in bedroom next to bed. Review of causative factors: unsteady gait/muscle weakness. IDT determined root cause of fall to be: Self transfer to her bed. New/different interventions now in place related to Root Cause: offer to lay down after lunch.
The Fall Log, recorded by individual resident indicated R147 had 18 falls:
1/22/18, in the dining room with no injury at 6 p.m. the intervention was 3 sleep observation and 3 day bowel and bladder tracking.
1/25/18, in bedroom with no injury at 11:30 p.m. the intervention was PT [physical therapy] to screen, x-ray right foot/ankle.
1/27/18, in hallway with no injury at 5:40 p.m. the intervention was medical workup and pain management.
1/29/18, in hallway with no injury at 1:25 p.m. the intervention was no skid footwear, new fall risk

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2 830	Continued From page 33	2 830		

assessment.
2/5/18, in dining room with no injury at 6:50 p.m. the intervention was to offer and encourage rest in bed after lunch.
2/10/18, in dining room with no injury at 11:20 a.m. intervention was continue to offer rest periods.
2/23/18, in dining room with no injury at 4:33 p.m. intervention was to redirect to sit down in dining room.
2/25/18, in dining room, with no injury, at 11:50 a.m. intervention was to have therapy screen.
3/20/18, in hallway with 5.0 x 5.0 centimeter (cm) bump on right side of head at 4:40 p.m. intervention placed on 1:1 for short period, 30 minutes due to aggression.
4/6/18, in dining room/lounge with no injury at 2:10 p.m. the intervention was medical workup.
4/22/18, in dining room with no injury at 2:20 p.m. the intervention was to attempt to redirect from other residents.
5/8/18 in the lounge with no injury at 11:00 a.m. the intervention was redirect resident from other resident's space.
5/24/18, in another resident's room/bathroom with no injury at 10:00. The intervention was to do 3 day bowel and bladder study.
6/7/18 in the dining room with no injury at 5:15 p.m. the intervention was to offer rest periods with fluids and snacks.
7/26/18, by the nurse's station at 3:40 p.m. sent to the emergency room, resulted in a hip fracture. Had surgery on 7/27/18, returned to facility on 7/31/18.
8/2/18, in bedroom with no injury at 3:30 p.m. intervention was offer to lay down after lunch.
8/7/18, in dining room with no injury at 6:15 p.m. the intervention was chair pad alarm on wheelchair.
8/9/18, in dining room with no injury at 8:30 p.m.

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2 830	Continued From page 34 the intervention was continue with therapy to help get stronger to use walker. R147 had between 11 and 15 falls (conflicting information in the chart and on the fall log) prior to the fall with hip fracture on 7/26/18; and 1 to 3 falls after returning to the facility. The facility lacked patient centered interventions, or different interventions for each fall. R26's Admission Record printed on 8/23/18, indicated R26 had diagnoses that included repeated falls and dementia. R26's annual MDS dated 6/6/18, indicated R26 had cognitive loss and dementia, impaired communication, and had a decline in continence R26's care plan revised 12/31/16, indicated the R26 wandered, rummaged, and shopped through others belongings, and believed they were hers. The care plan indicated R26 would yell and become angry with redirection, was at risk for falls related to history of falls, impaired mobility, medication, Alzheimer's and need for assist with cares. On 6/6/18, a hand written note indicated scoop mattress, gripper socks at bedtime, bed at seated heights, non-skid footwear. Frequent checks while in bed, attempt to redirect resident then having increased behaviors. The care plan indicated R26 ambulated with walker, but did not indicate that R26 would walk away from walker, or leave walker behind objects. On 8/20/18, at 7:55 p.m. R26 was observed walking away from the dining room without her walker, RN-H noticed after R26 had walked the length of the dining room to the nurse's station, at least 15 feet. On 8/21/18, at 9:49 a.m. R26 was observed walking through the dining room without her walker. A housekeeper brought it to her. NA-D and NA-H were in dining room, and did not notice. A nurse passing medications did not notice.	2 830		

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2 830	Continued From page 35 On 8/21/18, at 10:06 a.m. R26 was observed 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?" On 8/21/18, at 10:16 a.m. R26 was observed walking without her 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: On 10/14/17, at 12:17 a.m.. Found sitting on side mat on floor next to the bed in another resident's room. Was alert, smiling, stated, "I got down here, now I can't get up." Denied injury or pain. Able to move all extremities independently. Assisted to stand and walked with staff to her room without problem. Neuro check intact. On 11/21/17, at 5:32 p.m. One week follow-up note (R26's medical record lacked documentation of a fall one week prior). Resident appears to be at baseline, no residual effects noted post fall, no injuries observed, denies pain at time of assessment. On 12/13/17, at 5:02 p.m. Resident had witnessed fall. Per witness statements resident was standing at nurses station and backed up. Another resident reached out for her and grabbed her hand, and pulled her back causing resident to lower herself to the ground. Resident laughed and stated, "I'm okay, 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 heard walker fall on the ground, and found resident lying on right side on the ground. NA notified writer, and writer assessed resident. ROM to all extremities per baseline, denies pain.	2 830		

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Writer assisted resident to lie down in bed as it was reported she did not sleep through the night last night.
On 1/11/18, at 8:55 a.m. Resident had a witnessed fall at approximately 8:00 a.m. Writer assessed resident and noted a golf ball sized lump to left side of head. Resident denied pain however, when asked if she was in pain held the left side of her head. Some weakness noted to bilateral hands/legs and weak gait, send resident to Emergency Room for evaluation due to lump on head. Resident left via ambulance at approximately 8:45 a.m. At 11:09 received update from Emergency Room, CT [Cat Scan] of head, shoulder and spine negative.
On 5/7/18, at 1:21 p.m. R26 had an witnessed fall in main dining room next to counter where packages of sugar, creamers, are located. She hit her head on wall and railing. She has one inch swelling on back of her head. Neuro/vitals started, able to move all extremities, dry brief; took to bed and has stayed in her bedroom. Applied ice pack to back of head. Placed on 15 minute checks
On 5/29/18, at 10:45 p.m. Resident found sitting on floor two separate times. #1. Sitting on floor on buttocks, holding head. #2. Found in another resident's room sitting on floor with walker in front of resident. No injury. Staff monitoring with 15 minute checks initiated at 10:15 p.m.
On 7/13/18 at 7:10 p.m. Unwitnessed fall of resident in hall. Resident was lying flat down on floor with snacks and other things in her hands. Bridge of nose had 3 cm lesion that was bleeding; cleaned and applied bandage. Resident nose was bent. Used Hoyer to wheelchair, sent to Emergency Room for evaluation at 8:30 p.m. Resident returned around 12:30 a.m. by ambulance with papers indicating CT scan was normal, and expect resident to be stiff and sore

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2 830	Continued From page 37 for the next few days. Resident is sleeping in bed at this time. According to the facility fall log R26 had 10 falls: 11/30/17, fell in another residents room, with unnamed injury, at 11:20 a.m. Intervention was sent to Emergency Room for evaluation. 12/13/17, fell by nurses station with no injury at 3:20 p.m. Intervention indicated, "None see nursing note" 12/13/17, in another resident's room, received skin tear, at 8:20 p.m. The interventions was, MD to evaluate medications at the next scheduled visit [there was no indication when MD-A would be there]. 1/11/018, in resident's room with unnamed injury, at 8:00 a.m. The interventions listed were sent to Emergency Room for evaluation, orthostatic blood pressure x 3 days, Debrox drops [for ears]. 4/3/18, at nurse's desk with no injury at 11:15 p.m. The intervention was to remind staff to put on gripper socks and use walker. 5/6/18, in main dining room with no injury at 11:45 p.m. The intervention was a 7 day sleep study. 5/29/18, in hallway at 8:30 p.m. with unnamed injury and 10:15 p.m. with no injury. The intervention was notified MD in regards to fall, no medications. 7/13/18, at nurse's station with no injury at 11:15 a.m. No interventions were listed. 7/13/18, in hallway at 7:10 p.m. No interventions were listed. R26 was sent to the Emergency Room and returned at 112:30 a.m. on 7/14/18, with no injuries per CT scan. 8/10/18, at nurse's station, no injuries, at 6:10 p.m. The intervention was 3 day orthostatic blood pressures and therapy. R26's fall logs did not match chart documentation, and identified interventions did not coincide with the cause of the falls. The facility lacked a coordinated and resident	2 830		

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	00598	A. BUILDING: _____ B. WING _____	08/23/2018

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2 830	Continued From page 38 centered approach to falls. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents avoid falls, falls that occur are fully analyzed for root cause and appropriate interventions are put into place to avoid future falls The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	2 900		10/2/18

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2 900	Continued From page 39 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use was maintained during wound care for 1 of 3 residents (R15) observed during wound care. In addition, the facility failed to ensure daily wound care was documented and wound staging was accurate for R15's wounds. Findings include: R15's quarterly Minimum Data Set (MDS) dated 5/25/18, indicated diagnoses that included paraplegia, pressure ulcer of the left buttock, pressure ulcer of the coccyx, and local skin infection of the skin and subcutaneous tissue. In addition, the MDS indicated R15 had two Stage 4 pressure ulcers (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole [rolled edges], undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury). The MDS also indicated R15 received pressure ulcer care, had intact cognition, and did not reject cares. R15's care plan dated 9/21/17, indicated R15 had Stage 4 healing pressure ulcers on admission, with Methicillin-resistant Staphylococcus aureus infection (MRSA; a type of staph bacteria that is resistant to many antibiotics) and received wound dressing changes. The care plan directed staff to monitor and document the wound size, appearance, and to stage the wounds. In addition, the care plan directed staff to follow the	2 900	corrected	

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2 900	Continued From page 40 facility policies/protocols for the prevention/treatment of skin breakdown and administer treatments as ordered. On 8/22/18, at 11:01 a.m. R15 stated he had concerns his wound care was not being done twice daily as ordered. R15 stated wound care had not been done the previous evening shift on 8/21/18. R15 stated he had not refused the nurse to do it, and stated it was not even offered. R15 further stated at times, the nurses did not do it twice a day. On 8/23/18, at 8:13 a.m. registered nurse (RN)-B was observed to provide wound care for R15's two pressure ulcers on the coccyx and the left buttock areas. RN-B stated to R15 she was going to do the wound care. RN-B went to the bathroom and washed her hands, half filled an emesis basin with warm soapy water, half filled a wash basin with plain water, and set both basins on the bedside table. RN-B took an empty wash basin and set it to the right of the wash basin with plain water. RN-B donned a clean gown. RN-B stated R15 had history of MRSA infection in the wound beds. RN-B applied gloves, and removed a soiled dressing around R15's suprapubic stoma site. RN-B picked up a bottle of wound cleanser, and sprayed the area twice. RN-B used gauze to wipe the area, and used an alcohol wipe to clean the skin and catheter tube, and tossed the wipe in the garbage. RN-B removed her gloves and without performing hand hygiene, reached into the closet (which contained the wound supplies) and took out 4 centimeter (cm) by 4 cm gauze. Without performing hand hygiene, RN-B donned clean gloves, opened the gauze wrap, applied the clean gauze dressing around R15's stoma site, and taped it down. RN-B removed her soiled gloves, asked R15 to turn to the left side, and without	2 900		

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2 900	Continued From page 41 performing hand hygiene, donned a clean pair of gloves. RN-B reached into the packet of gauze, took a handful of gauze, and dropped them into the plain water basin. RN-B grabbed another handful of gauze and placed them into the empty basin. RN-B reached into the box with Normal Saline (NS) solution and grabbed one tube, opened the cap, and squeezed the solution on the gauze in the empty basin. RN-B cleansed both wounds with the soapy water, then reached into the basin with gauze soaked in plain water, and obtained multiple gauze pads which she used to cleanse the wounds. RN-B reached into the dry gauze packet, grabbed several pieces of gauze, and used them to dry both pressure ulcers. RN-B did not change gloves or perform hand hygiene while doing the wound care on both pressure ulcers. RN-B reached into the third basin which had multiple gauze soaked in Normal Saline solution, and used these to start packing the wound. Before covering the wounds with a dressing, the surveyor intervened and asked RN-B to remove the soiled gloves as she had used them to clean the wounds. RN-B removed the soiled gloves, and reached for clean gloves. Without performing hand hygiene, RN-B started applying clean gloves. Again the surveyor intervened, and asked RN-B to wash her hands before donning clean gloves. RN-B proceeded to pack both pressure ulcers with multiple gauzes moistened with Normal Saline solution, applied ABD dressings on top of the pressure ulcers, and taped the dressings to the skin. RN-B removed her gown and gloves, tossed them in the garbage, and without performing hand hygiene, applied clean of gloves. RN-B moistened two pieces of gauze with the wound cleanser, cleansed an open area on R15's left great toe, and patted the area dry. RN-B picked up the basins with soapy water and plain water, brought	2 900		

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2 900	Continued From page 42	2 900		

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.

Review of R15's daily wound treatment documentation, indicated the following:
8/14/18: Evening shift, no wound care completed. A note indicated R15 was out of the facility.
8/15/18: Day shift, no wound care completed.
8/16/18: Day shift, no wound care completed.
8/21/18: Evening shift, no wound care completed. A progress note indicated R15 was sleeping when the nurse approached him.
8/22/18: Evening shift, no wound care completed. A note indicated R15 refused.

On 8/23/18, at 9:08 a.m. licensed practical nurse (LPN)-B verified R15 was not out of the facility on 8/14/18. LPN-B verified wound care had not been documented as completed on 8/14/18, 8/15/18, and 8/16/18. LPN-B stated the nurses were expected to write a note to explain why it was not completed. LPN-B stated on 8/15/18, R15 had an appointment at 9:00 a.m. with pick up 8:00 a.m. however, LPN-B was not sure when R15 had returned to the facility, and there was no documentation that wound care had been offered or attempted to be completed after the appointment. LPN-B stated R15 had no medical appointment on 8/16/18, and there was no documentation to explain why wound cares were not completed. LPN-B stated he would expect the nurses to reapproach R15 if wound care was refused or not completed, and all the nurses were to document attempts in the medical record. LPN-B also verified on 8/21/18, and 8/22/18, nurses should have communicated to the next nurse to approach R15 to do the wound care as ordered. LPN-B stated R15 had a history of

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2 900	Continued From page 43	2 900		

MRSA in the pressure ulcers. and he would expect the staff to follow standard infection control protocol for wound care, glove use and hand hygiene to prevent infections to the wounds. LPN-B further stated RN-B was supposed to use separate gloves for each of the pressure ulcers when cleaning them, and was to remove the soiled gloves, wash hands, and apply a clean pair of gloves before packing the wounds and applying the clean ABD dressing.

On 8/23/18, at 9:21 a.m. the director of nursing (DON) stated she would expect RN-B to have completed wound care following proper infection control procedures. The DON also stated staff nurses were to document wound care, and expected them to reapproach R15 to complete wound care. .

On 8/23/18, at 10:06 a.m. RN-B stated R15's wound care was not intended to be a sterile procedure. RN-B stated if it was a sterile procedure, she would have removed her gloves, washed her hands, and proceeded with the wound care. RN-B stated this was not the case, and this was how she understood she was to complete the wound care. RN-B verified she had not washed her hands and removed gloves as required on multiple times when completing wound care. RN-B acknowledged R15 was at risk for developing infections, and she stated she had completed the wound care as taught.

The facility Pressure Injury/Skin Integrity/Wound Management policy revised 11/16, directed the licensed nurses to daily and/or routinely document the residents skin condition, the response to care and treatment to the skin.

The facility Hand Washing policy dated 4/1/08,

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2 900	Continued From page 44 directed staff to scrub their hands with soap and water thoroughly for 20 seconds, and staff were to wash fingers and nails. The facility Gloves, Non-Sterile policy dated 4/1/08, directed staff, while wearing gloves, to avoid handling personal items to prevent contamination; staff were also to remove gloves that were contaminated as soon as possible, and staff were to wash their hands upon removal of the gloves. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents do not develop a pressure ulcer unless it is clinically unavoidable, and residents who do have pressure ulcers are receiving the proper care and services needed to promote healing, prevent infection and promote new pressure ulcers from developing. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that:	2 930		10/2/18

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2 930	Continued From page 45 B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. 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. Findings include: R148's admission Minimum Data Set (MDS) dated 8/15/18, indicated diagnoses that included dysphagia (difficulty swallowing, traumatic brain injury (TBI) and muscle weakness. In addition, the MDS identified R148 received tube feeding. R148's Physician Order dated 8/8/18, indicated R148 had an order for Jevity 1.0 (nutrition for tube feeding), 65 milliliter (ml) per/hour for 21 hours continuously from 8:00 a.m. to 5:00 a.m. In addition, a physician order dated 8/9/18, indicated R148 was to receive 150 ml water flushes via gastrostomy (g) tube four times daily for a total of 600 ml. R148's care plan dated 8/16/18, indicated R148 did not receive anything by mouth, and she received tube feeding. The care plan indicated	2 930	corrected	

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2 930	Continued From page 46	2 930		

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 preparing R148's medications. RN-D crushed seven different medications in separate plastic bags and mixed two packets of powdered Potassium Chloride 20 milliequivalent (mEq) in five ounces of water. RN-D stated she was going to give all the medications via g-tube. At 8:11 a.m. RN-D arrived at R148's room, went to the bathroom and obtained 200 ml of water in a graduate cylinder. RN-D approached R148, indicated she was going to administer medications and start her enteral feeding via g-tube. RN-D pulled the bedside table and set down the small cup with Potassium Chloride mixed in water, and the rest of R148's morning medications crushed in little plastic bags. After applying gloves, RN-D was picked up the g-tube, removed the tab closure, and inserted a syringe with air into the feeding port as she listened with a stethoscope to check for tube placement. RN-D clamped the g-tube, took the syringe off the port, then separated the barrel and plunger. RN-D inserted the barrel into the g-tube port and administered 15 ml of water, clamped the g-tube, poured the Potassium Chloride liquid into the barrel and flushed with 10 ml of water. RN-D clamped the g-tube and poured another 10 ml of water into the barrel. RN-D emptied the crushed medication powder into the water in the barrel, and released it to adminsitered the medications. RN-D followed this with a 10 ml flush of water. RN-D repeated this process of emptying the crushed powdered medications five times without mixing the medications with water before pouring

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2 930	Continued From page 47 them into the barrel. Once finished, RN-D went into the bathroom and obtained another 200 ml of water. RN-D returned to R148's bed side, and flushed the tube. RN-D continued to administer the crushed powdered medications on two separate occasions followed by water flushes. RN-D stated she had used a total of 350 ml of water to complete the water flushes. RN-D removed her gloves, dumped the remaining 50 ml of water, cleansed her hands, and left the room without starting R148's tube feeding. At 8:25 a.m. RN-D reviewed R148's physician orders and verified R148 was to receive 150 ml of water flushes four times a day. RN-D stated she had given R148 more water because she had a problem with medications not draining, and she was going to hold off the tube feeding "To let the medications settle." RN-D stated she had not mixed the medications prior to administering them, because she had asked RN-E, who told her she would pour the powder into the syringe barrel with water 5 ml to 10 ml of water, and then follow with a water flush of the same amount. RN-D stated she did not know the policy on tube feeding, and that was why she had asked RN-E. RN-D further stated she was going to hold off on starting the tube feeding. On 8/22/18, at 8:50 a.m. RN-E stated medications should have been dissolved in water using the little medication cups before g-tube administration. RN-E stated R148 should have not gotten the extra water (200 ml of water flush). RN-E stated she was not aware the tube feeding was not running as ordered, and RN-D should have gotten an order to hold the tube feeding from the nurse practitioner (NP). RN-E verified R148's tube feeding was supposed to be running from 8:00 a.m. to 5:00 a.m. (21 hours	2 930		

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2 930	Continued From page 48 continuously) On 8/22/18, from 8:52 a.m. to 9:01 a.m. the tube feeding was observed not running. At 9:02 a.m. RN-E approached and stated she had gotten an order to hold the tube feeding for three hours due to the extra water given and would re-start the tube feeding 11:00 a.m. On 8/22/18, at 1:40 p.m. RN-F verified the RN-D had not demonstrated competency skills related to medication administration through a g-tube. RN-F stated all the licensed nursing staff had a clinical check list. On 8/22/18, at 1:49 p.m. the director of nursing (DON) stated she would have expected the nurse to dissolve the medications in water before administering them according to the facility policy. The DON stated RN-D should have followed the physician orders for the water flushes, and should have started the tube feeding timely as ordered, and if not, to get an order to hold it. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents with tube feedings are receiving the proper care and services needed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 930		

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2 930	Continued From page 49 (21) days.	2 930		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adaptive eating equipment was provided for 1 of 1 residents (R117) reviewed for nutrition. R117's Admission Record printed on 8/23/18, indicated R117's diagnoses included dysphasia (difficulty swallowing) and cancer of throat or lung. R117's admission Minimum Data Set (MDS)	2 945	corrected	10/2/18

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	00598	A. BUILDING: _____ B. WING _____	08/23/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 945	Continued From page 50 dated 5/4/18,indicated R117 had difficulty eating due to sequencing errors and declining coordination. The MDS further identified R117 required assistance with eating, required a mechanical soft consistency diet (chopped, ground, pureed foods, and foods that readily break apart without a knife). R117's goal listed was to work toward resident highest level of independence with eating. On 5/4/18 a Physical, Occupational and Speech Therapy form instructed: "Pt [patient] to use scoop plate [plate with elevated edges] at all meals." R117 was observed for meals on: 8/20/18, for the supper meal. 8/21/18, for the breakfast meal. 8/22/17, for the breakfast meal. The facility failed to provide the ordered scoop plate for any of those meals. On 8/23/18, at 8:25 a.m. registered nurse (RN)-H verified R117 had not had a scoop dish. On 8/23/18, at 9:20 a.m. the director of dietary services (DD) indicated the normal process was an order was called down to kitchen, dietary staff modifies the Adaptive Equipment list based on information they get from occupational therapy (OT). However, if OT was not involved the changes have to be caught, or recommended by nursing assistants (NA) to help residents continue to be as independent as possible. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents who need adaptive equipment for eating are receiving these	2 945		

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2 945	Continued From page 51 interventions. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 945		
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. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper drying and storage of stainless steel serving pans to prevent bacteria formation and potential for foodborne illness. This deficient practice had the potential to affect all 165 residents who ate food prepared in the facility kitchen. Findings include: On 8/20/18, at 1:27 p.m. during the initial observation of the kitchen with the dietary manager (DM), four stainless steel steam table pans were checked in the storage area near the pots and pans sink. Two of the pans had been put away wet. Two more stainless steel pans stored in the cooks area were also found to be stored	21015	corrected	10/2/18

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21015	Continued From page 52 wet. The DM verified the pans were put away to be used again, and stated the pans were to be air dried before being stacked for use. On 8/23/18, at 2:07 p.m. during a second observation of the kitchen, four stainless steel pans were checked on a storage shelf in the cooks area. Of the four pans, one pan was noted to be wet and another had been put away with food residue remaining on the pan surface. The DM verified the wet pans and the soiled pans. SUGGESTED METHOD OF CORRECTION: The Director of Dietary or designee could develop, review, and/or revise policies and procedures to ensure kitchen cook and bakeware are stored clean and dry. The Director of Dietary or designee could educate all appropriate staff on the policies and procedures. The Director of Dietary or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced	21025		10/2/18

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21025	Continued From page 53 by: Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 1 of 6 residents (R4) receiving pureed food. Findings include: R4's Admission Record printed 8/23/18, indicated R4 had diagnoses that included unspecified dementia and Alzheimer's disease. R4's quarterly Minimum Data Set (MDS) dated 5/3/18, indicated R4 had moderately impaired mental status, and required set up assistance, and encouragement or cueing with eating. R4's diet order dated 4/08/18, directed a low salt diet, low fat/cholesterol 3 gram sodium diet. R4's care plan printed 8/16/18, indicated R4 was edentulous (lacking teeth) and received a pureed, low sodium, low fat, low cholesterol diet with honey (textured) liquids. On 8/20/18, at 4:54 p.m. the supper food temperatures taken by dietary aide (DA)-A included french fries at 135 degrees Fahrenheit (F) and mashed potatoes at 132 degrees F prior to beginning food service. No action was taken to improve the temperature of these menu items. DA-A began serving meals at 5:25 p.m. On 8/22/18, at 1:20 p.m. as the last food trays were served to residents, pureed meatloaf registered a temperature of 100 degrees F, and pureed spinach was 110 degrees F with DA-B. Food temperatures were not observed to have been taken during the meal service and action to reheat foods was not observed.	21025	corrected	

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21025	Continued From page 54 On 8/23/18, at 11:19 a.m. R4 stated the food he received was sometimes not hot. On 8/23/18, at 1:33 p.m. the dietary manager (DM) stated when food temperatures of hot foods in the dining rooms are low, food service staff are supposed to call the kitchen and kitchen staff would bring the food back to the kitchen and re-heat it. SUGGESTED METHOD OF CORRECTION: The Director of Dietary or designee could develop, review, and/or revise policies and procedures to ensure food is served hot and at the appropriate temperatures. The Director of Dietary or designee could educate all appropriate staff on the policies and procedures. The Director of Diatary or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21035	MN Rule 4658.0620 Subp. 2 Frequency of Meals; Snacks Subp. 2. Snacks. The nursing home must offer evening snacks daily. "Offer" means having snacks available and making the resident aware of that availability. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure substantial evening snacks were offered for 3 of 3 residents	21035	corrected	10/2/18

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21035	Continued From page 55 (R128, R4, R118) who received meals in the Cedar unit dining room and who were reviewed for dining services. Findings include: In the Cedar unit, the posted meal times were: -Breakfast: 8:20 a.m. -Lunch: 12:20 p.m. -Dinner: 5:00 p.m. There were 15 hours, 25 minutes between the posted dinner and breakfast times. R128's Admission Record dated 8/23/18, indicated R128 had diagnoses that included dementia with behaviors, anemia, and muscle weakness. R128's Order Summary Report, dated 8/23/18, indicated R128 was 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. R128's care plan dated 5/5/18, indicated R128 had lost weight during the last 3 years resulting in a body mass index (BMI) at the lowest of an acceptable range. R128 was to receive increased calorie foods and nutritional supplements at medication pass times. On 8/22/18, at 7:00 a.m. R128 was observed in her wheelchair, in the dining room of the Cedar unit. Continuous observations began on 8/22/18,	21035		

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21035	Continued From page 56 from 7:47 a.m. until 9:22 a.m. On 8/22/18, at 7:47 a.m. R128 was observed in her wheelchair in the unit dining room. R128 was not seated at a table, and did not have coffee or juice. R128 was not approached, offered a beverage or an activity at any time. R128 continued to sit in her wheelchair, sometimes grinding her teeth until 8:59 a.m., when R128 was pushed in her wheelchair to at table near the window. R128 was still offered no beverage or food item. From 9:07 a.m. until 9:20 a.m., R128 was observed with her head forward as if dosing. At 9:22 a.m. a staff person sat down to assist R128 to eat her breakfast. At no time was R128 offered coffee, juice, or a snack to tide her over until breakfast. R128 received her breakfast meal at 9:22 a.m., which is 57 minutes past the posted time of 8:25 a.m. for the Cedar Unit breakfast meal. This was 16 hours, 22 minutes after the posted dinner time for the Cedars unit. Review of R128's Documentation Survey Report printed 8/23/18, indicated HS snacks are as needed (PRN). R128's documentation indicated she had 1 bedtime (HS) snack in June (but before supper), 1 HS snack in July (before supper), and none in August. R4's Admission Record dated 8/23/18, indicated R4 had diagnoses that included unspecified dementia, Alzheimer's disease, and dysphagia (difficulty swallowing). R4's quarterly Minimum Data Set (MDS) dated 5/3/18, indicated R4 had moderately impaired cognition.	21035		

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21035	Continued From page 57 R4's diet order dated 4/08/18,was for a low salt diet, low fat/cholesterol 3 gram sodium. R4's care plan printed 8/16/18, indicated R4 was edentulous (no teeth), and received a pureed, low sodium, low fat, low cholesterol diet with honey (textured) liquids. Evening snack records for R4 were requested but not received. The written request was returned with a notation that snacks consumed by R4 were not documented. R118's Admission Record dated 8/23/18, indicated R118 had diagnoses that included hemiplegia and dysphagia. R118's annual Minimum Data Set (MDS) dated 02/02/18, indicated R118 needed extensive assistance with eating with one person providing physical assistance. R118's care plan dated 2/5/18, indicated R118 required extensive assist of one for all meals. The nutrition portion of the care plan included intervention of extensive hands-on assistance to total assistance, to finish the meal, and instruction to sit on R118's left side to assist. R118's evening snack records from 7/1/18 - 8/22/2/18, were requested. Records provided indicated R118 ate an evening snack at 9:50 p.m. on 8/3/18. The Documentation Survey Report provided for July 2018, indicated that R118 ate one evening snack at 8:33 p.m. and 4 snacks between the hours of 10:00 p.m. and 6:00 a.m. for the month. On 8/23/18, at 3:13 p.m. nursing assistant (NA)-J stated usually if a resident stated they were	21035		

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21035	Continued From page 58	21035		

hungry during the evening, she would give them something to eat. NA-J stated she would check for special diets, and look in the back room refrigerator to see if they had a labeled snack specifically for that individual. NA-J said she made an effort to give the labeled snacks, specific snack orders for example, for diabetics, to the recipients between 7-8 p.m. NA-J stated she knew who ate an evening snack by seeing them sitting outside their room eating, or if a resident couldn't feed themselves, she would stay with the resident and then record in the computer what was eaten for that snack.

On 8/23/18, at 3:13 p.m. licensed practical nurse (LPN)-L stated staff offer snacks of ice cream or juice to residents. LPN-L stated a lot of residents do not want an evening snack because supper ended around 6:00 p.m. She said the diabetic residents do get evening snacks, either specially labeled snacks, or staff offer a snack from the stock supply if there was not a specifically labeled snack. For residents that cannot answer, LPN-L would offer some extra pudding as part of the med passing process. LPN-L stated a lot of the residents are sound asleep by 8:00 p.m. so she felt lucky to get their medications to them. She stated a lot of the residents make statements they had three good meals and, "Oh, I'm eating again." LPN-L said the nursing assistants are the ones who record evening snack intakes.

On 8/23/18, at 2:07 p.m. dietary manager (DM) stated nursing staff record the evening staff intake. When asked to check evening snack intake for R118, she looked in R118's electronic health record and stated the last time staff recorded when R118 ate an evening snack was 8/13/18.

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21035	Continued From page 59 The facility policy Meal Times/Frequency dated 1/27/18, directed no more than 14 hours elapse between a substantial evening meal, and breakfast the following day unless a nourishing snack is offered to residents at bedtime. The policy directed the facility offer nourishing snacks, and offering such snacks allows there to be up to 16 hours between the evening meal and the following day breakfast meal. Nursing staff, per the policy, was responsible for offering an evening snack, and for documentation of the snack in the electronic record. The facility policy Hour of Sleep (HS) Snack dated 1/18, directed each resident would be offered an HS snack. The policy directed the facility would have snacks available, and make the residents aware of that availability. After supper snacks would be made available at the nursing station for each resident. Refusals of snacks were to be documented in the electronic record. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are offered a substantial evening snack when there are over 15 hours between the evening meal and breakfast. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21035		

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21390	Continued From page 60	21390		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand washing after peri cares for 2 of 4 residents (R4, R128) reviewed for bowel and bladder. Findings include:	21390	corrected	10/2/18

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21390	Continued From page 61 R4's quarterly Minimum Data Set (MDS) dated 5/30/18, indicated R4 had moderately impaired cognition, and was occasionally incontinent of bladder. R4's MDS also indicated he required extensive assistance with personal hygiene and toileting. On 8/23/18, at 7:43 a.m. nursing assistant (NA)-0 entered R4's room to offer breakfast and morning care. NA-O put on gloves prior to assisting R4 with washing his face, washing under arms, and peri areas. NA-O removed an incontinent pad that was wet with urine, and completed cares. Without removing the soiled gloves, NA-O assisted R4 in putting on a new gown, pulling up the comforter, changing the garbage, and adjusting the bed height using an electric control. After that, NA-O went into R4's bathroom and removed his gloves, and sanitized his hands. On 8/23/18 at 7:58 a.m., NA-O stated he did touch items after providing peri cares. NA-O stated they had been taught to wash hands after glove removal, but sometimes they forgot. R128's Admission Record printed 8/23/18, indicated R128 had diagnoses that included dementia with behaviors, and muscle weakness. R128's quarterly 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 toileting, and staff were to provide peri cares after any incontinent episode. R128's care plan dated 5/5/18, indicated R128	21390		

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21390	Continued From page 62	21390		

had dementia with behaviors, history of a neurogenic bladder, and to provide peri cares after any incontinent episode.

On 8/22/18, at 9:36 a.m. NA-N wheeled R128 from the dining room to her bedroom to assist R128 onto the toilet. NA-N locked R128's wheelchair next to the toilet and put on gloves. NA-N assisted R128 to hold the grab bars with two hands, and using a transfer belt, assisted R128 to standing, then transferring and sitting on the toilet. After R128 urinated in the toilet, NA-N wiped R128's peri-area and assisted R128 in pulling up her pants. With the soiled gloves, NA-N moved the wheelchair position by using the handles, took off the transfer belt, and then removed the gloves. Without performing hand hygiene, NA-N flushed the toilet, rolled up the transfer belt and put it in her pocket, drew up the garbage bag, placed a new bag in the container, unlocked the wheelchair brakes, and used the bathroom door handle to open the door and push R128's wheelchair into the hallway. When NA-N got to the soiled utility room, she entered and washed her hands.

On 8/22/18, at 9:45 a.m. NA-N stated she realized she forgot to wash her hands, and she had been taught to wash hands after glove removal. NA-N also stated that she was still touching "dirty" items so it made sense to wait until she was in the soiled utility room to wash hands.

On 8/23/18, at 8:20 a.m. licensed practical nurse (LPN)-B stated the goal was if a staff person touched the patient, they washed or sanitized their hands. LPN-B reiterated, if staff have skin contact, no matter what, they wash their hands. Hands should be washed or sanitized after glove

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	00598	A. BUILDING: _____ B. WING _____	08/23/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 63 removal, then staff can go back and adjust clothing bed height, etc. On 8/23/18, at 12:21 p.m. the director of nursing (DON) stated she expected hands to be washed or sanitized immediately after glove removal. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure proper hand hygeine is completed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		10/2/18

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21426	Continued From page 64 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the agency failed to ensure 3 of 5 residents (R142, R412, R108) Tuberculin Skin Test (TST) results were completed and appropriately documented. In addition, the facility failed to ensure 2 of 5 employees (E-A, E-B) TST results were documented appropriately per State regulation. Findings include: R142 was admitted to the facility on 7/15/18. R142 received a first step TST on 7/16/18, at 10:47 p.m. and it was read on 7/18/18, at 10:44 p.m. which was less than 48-72 hours. In addition, a second step TST had been administered on 7/28/18, however, the result was not read. R412 was admitted to the facility on 8/15/18. R412 had a first step TST administered and read on 8/16/18, and 8/18/18, however no symptom screening was completed. R108 was admitted to the facility on 7/5/18. R108 was administered a first step TST on 7/5/18, at 10:03 p.m. and was read on 7/7/18, at 5:18 p.m. less than 48-72 hours. On 8/1/18, at 2:57 p.m. registered nurse (RN)-E	21426	corrected	

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21426	Continued From page 65 verified all the identified concerns with completing the symptoms screening, missed second step TST and reading the TST results. E-A's personnel file identified a hire date of 6/25/18. E-A had a first step TST administered on 6/25/18, and read 6/28/18. A second step TST was administered on 7/3/18, and read 7/6/18, however the results we identified as negative with no induration in millimeters (mm). E-B's personnel file identified a hire date of 6/18/18. E-B had a first step TST administered on 7/26/18, at 9:00 p.m. and was read 7/28/18, at 2:40 p.m. with results identified as 0 mm and negative which was less than 48-72 hours. On 8/21/18, at 11:55 a.m. the director of human resources (HR)-A verified the employee files. HR-A stated she not identifie the TSTs being read early, and the induration not being including for the result. On 8/22/18, at 2:10 p.m. the director of nursing (DON) stated she would expect the staff to be reading the TSTs within 48-72 hours. The DON further stated all admits were supposed to have symptoms screenings completed for TB, and all residents TSTs were supposed to be read timely. SUGGESTED METHOD OF CORRECTION: The Director of nursing and/or designee could review and revise policies and procedures, train staff and monitor to assure Tuberculin Skin Tests (TST) are read, results documented; and assure that employees are screened for tuberculosis (TB) using a symptom screen, and by either a single step IGRA (Interferon Gamma Release Assay blood test) or a two-step TST and documented appropriately per State regulation.	21426		

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21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the ombudsman of a facility initiated transfer for 1 of 6 residents (R94) reviewed for hospitalization. Findings include: R94's admission Minimum Data Set (MDS) dated 7/2/18, indicated diagnoses which included	21925	corrected	10/2/18

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21925	Continued From page 67	21925		

septicemia, paraplegia and neurogenic bladder. R94's MDS also indicated R94 had admitted to the facility from the hospital on 6/23/28, and on the same day R94 was discharged back to the hospital.

On 6/23/18, R94's progress note indicated R94 was admitted to the facility from the hospital. The note further indicated R94 had a temperature of 102.1 Fahrenheit (F) and the nurse had called the provider at the hospital who gave an order to send R94 back to the hospital if R94 spiked another temperature. The progress note further indicated at 11:30 p.m. R94's temperature was 101.7 F, and R94 was sent back to the hospital at midnight.

On 6/25/18, R94's progress note indicated R94 was re-admitted to the facility on 6/25/18, with admitting diagnosis of sepsis, and an order for intravenous (IV) antibiotic.

On 8/22/18, at 10:18 a.m. the director of social service SS-A verified R94 had been discharged to the hospital on 6/23/18, and returned 6/25/18. SS-A verified she had not notified the ombudsman of R94's discharge to the hospital.

On 8/22/18, at 2:20 p.m. the regional ombudsman verified she had not been notified of R94's discharge to the hospital.

A policy on notification of the ombudsman was requested but not provided.

SUGGESTED METHOD OF CORRECTION:
The Director of Social Services or designee could develop, review, and/or revise policies and procedures to ensure the ombudsman received notification of all hospitalizations.

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21925	Continued From page 68 The Director of Social Services or designee could educate all appropriate staff on the policies and procedures. The Director of Social Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		

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. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (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. 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. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • 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	◉	○	○	
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." 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** 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** 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, *Transfilling of High Pressure Gaseous Oxygen Used for Respiration*. 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. 11.5.3.1 (NFPA 99)	◉	○	○	
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). 11.6.2 (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	**Features 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: o application site is dry prior to draping and use of surgical equipment. o pooling of solution has not occurred or has been corrected. o solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. o 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)	○	○	◉	

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
K400	

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

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
F5366029	Chris Jensen Health & Rehab Center	08/22/2018

Administrator: Amy Porter | Phone Number: 218-625-6400

Email address: aporter@chrisjensenhealth.com

State Fire Inspector: James A. Anderson, M.S.

These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

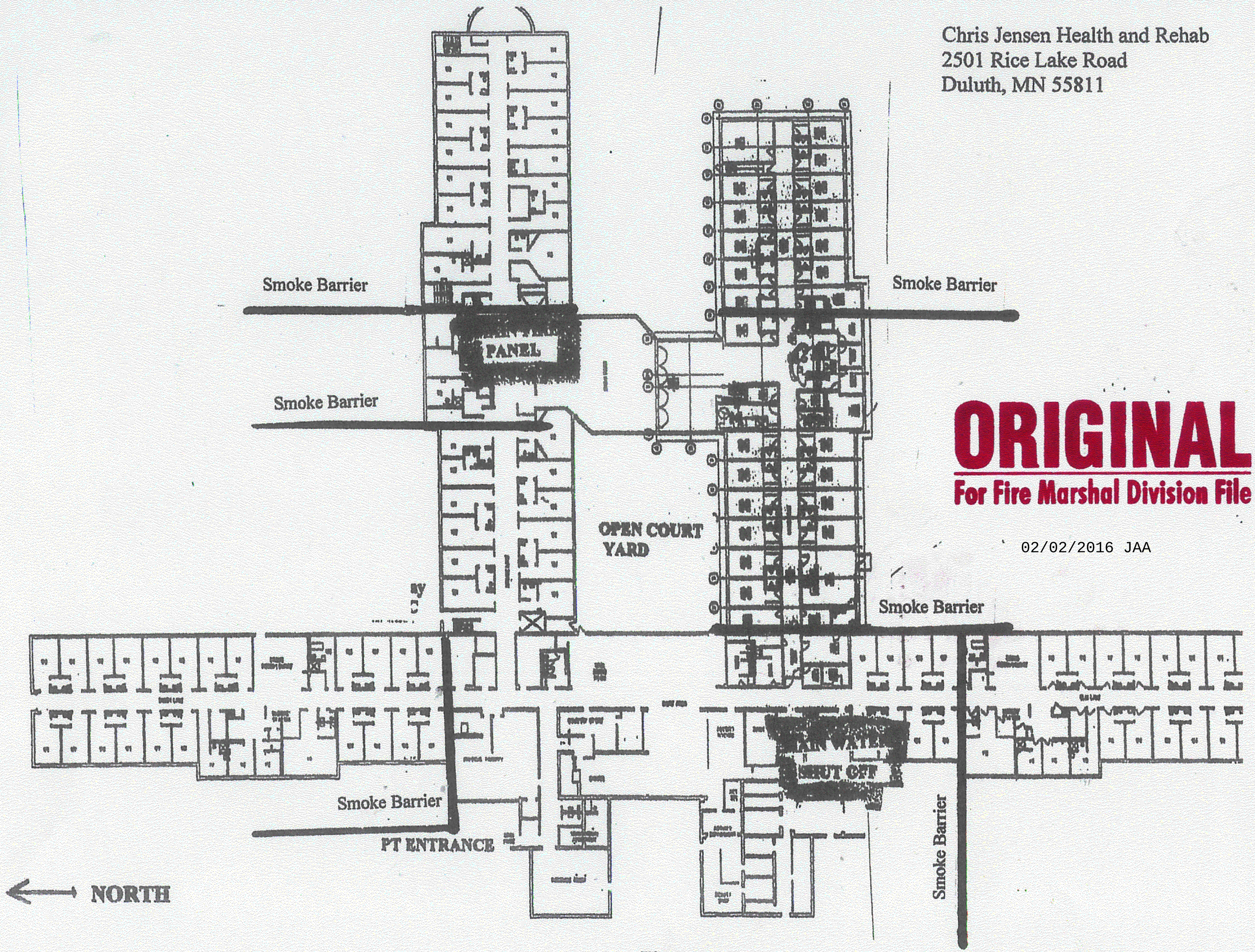
(●) **At the time of this inspection, this facility was found to comply with the requirements of the 2012 Life Safety Code applicable to:** [✔] **SNF/NF** [ ] **Hospital** [ ] **ICFMR** [ ] **ASC Facilities participating in the Medicare/Medicaid programs.**

( ) **The following fire/life safety deficiencies were found during this inspection:**

K TAG S& S	(●) **Draft Summary of Deficiency(ies)** ( ) **Revisit** ( ) **Clearance**
K341 SS=D	The smoke detectors located in the corridor outside of the Administrators office was installed within 36 inches of a HVAC vent diffuser.

File No: HC 140982

Chris Jensen Health and Rehab
2501 Rice Lake Road
Duluth, MN 55811



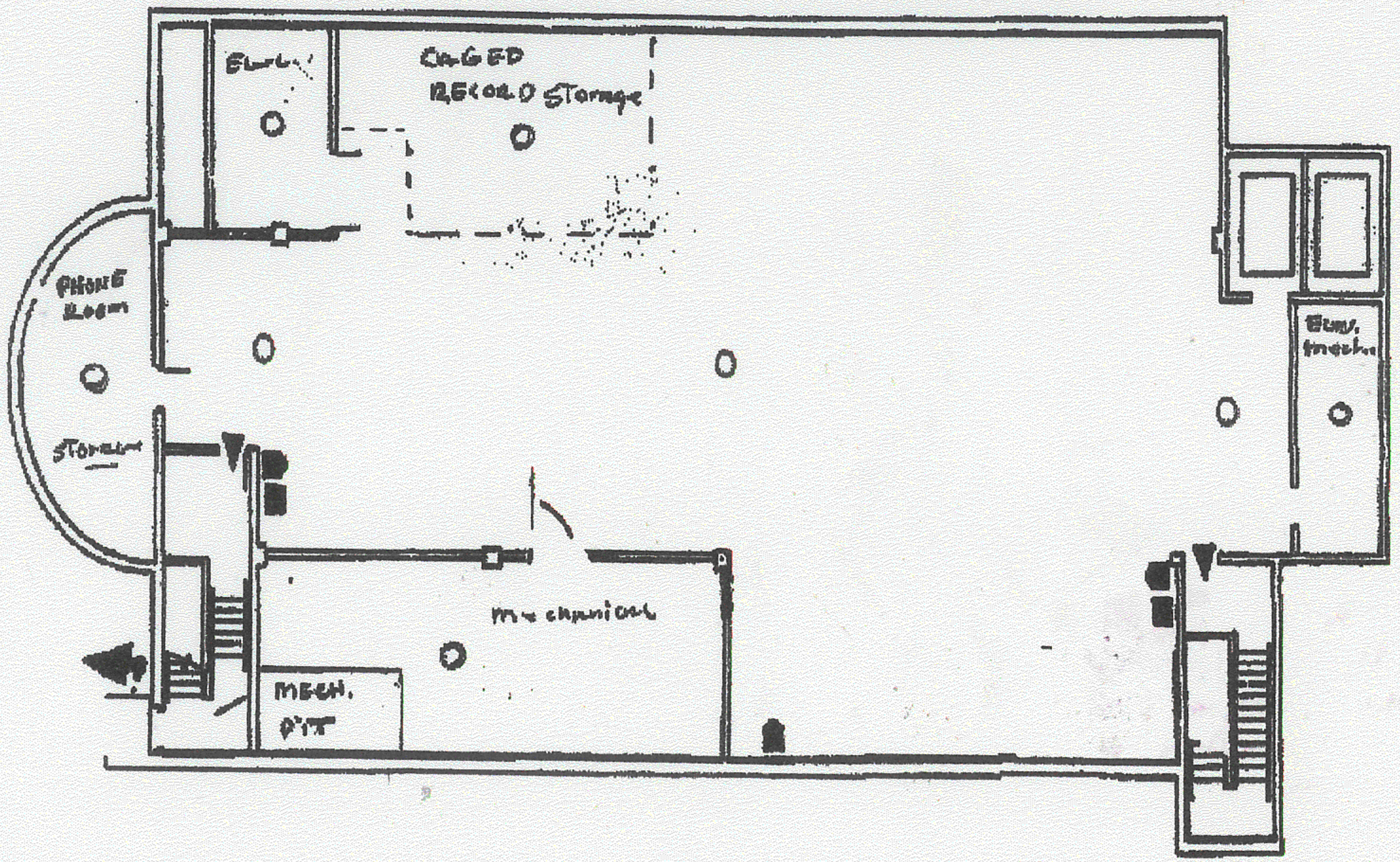
First Floor

ORIGINAL
For Fire Marshal Division File

02/02/2016 JAA

File No: HC 1400982

Chris Jensen Health and Rehab
2501 Rice Lake Road
Duluth, MN 55811



BASEMENT

ORIGINAL
For Fire Marshal Division File

02/02/2016 JAA